



WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
SIC CODE		EMPLOYER FEIN		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)
				LOCATION #: PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)	
		TO		
		CHECK IF APPROPRIATE		
		<input type="checkbox"/> SELF INSURANCE		
CARRIER FEIN	POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN	
AGENT NAME & CODE NUMBER		JMB Insurance Agency, Inc.		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX	MARITAL STATUS	OCCUPATION/JOB TITLE	
		<input type="checkbox"/> MALE	<input type="checkbox"/> UNMARRIED <input type="checkbox"/> SINGLE/DIVORCED		
		<input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED		
		<input type="checkbox"/> UNKNOWN	<input type="checkbox"/> SEPARATED		
PHONE		# OF DEPENDENTS	<input type="checkbox"/> UNKNOWN	NCCI CLASS CODE	
RATE	PER:	DAY	MONTH	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?
		WEEK	OTHER:		<input type="checkbox"/> YES <input type="checkbox"/> NO
					DID SALARY CONTINUE?
					<input type="checkbox"/> YES <input type="checkbox"/> NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?			TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE		
<input type="checkbox"/> YES <input type="checkbox"/> NO							
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.							CAUSE OF INJURY CODE
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
				WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL (NAME & ADDRESS)			INITIAL TREATMENT	
						<input type="checkbox"/> NO MEDICAL TREATMENT	
						<input type="checkbox"/> MINOR BY EMPLOYER	
						<input type="checkbox"/> MINOR CLINIC/HOSP	
						<input type="checkbox"/> EMERGENCY CARE	
						<input type="checkbox"/> HOSPITALIZED > 24 HRS	
						<input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
WITNESSES (NAME & PHONE #)							
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE		PHONE NUMBER			