



Indiana Worker's Compensation First Report of Employee Injury/Illness

Please Return Completed Form to: 402 W. Washington St., Room W196
Indianapolis, IN 46204-2753
(317) 232-3808

FOR WORKER'S COMPENSATION BOARD USE ONLY		
JURISDICTION	JURISDICTION CLAIM NUMBER	PROCESS DATE

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION										
SOCIAL SECURITY NUMBER		DATE OF BIRTH		SEX <input type="radio"/> MALE <input type="radio"/> FEMALE <input type="radio"/> UNKNOWN		OCCUPATION/JOB TITLE		NCCI CLASS CODE		
LAST NAME			FIRST	MIDDLE		MARITAL STATUS <input type="radio"/> UNMARRIED <input type="radio"/> MARRIED <input type="radio"/> SEPARATED <input type="radio"/> UNKNOWN		DATE HIRED	STATE OF HIRE	EMPLOYEE STATUS
ADDRESS (INCL ZIP)						HRS/DAY		DAYS/WK	AVG WG/WK	PAID DAY OF INJ SALARY CONT'D <input type="checkbox"/>
PHONE				# OF DEPENDENTS		WAGE \$		PER <input type="radio"/> HR <input type="radio"/> DAY <input type="radio"/> WK <input type="radio"/> MO <input type="radio"/> YR <input type="radio"/> OTHER:		

EMPLOYER INFORMATION				
EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP) University of Notre Dame 636 Grace Hall Notre Dame, IN 46556		EMPLOYER FEDERAL ID# 35-0868-188N	SIC CODE 8220	INSURED REPORT NUMBER
		LOCATION # 1	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
		PHONE # 574-631-5037		
CARRIER/ADMINISTRATOR CLAIM NUMBER			REPORT PURPOSE CODE	

Actual Location of Accident/Exposure (if not on employer's premises):

CARRIER/CLAIMS ADMINISTRATOR INFORMATION			
CLAIMS ADMINISTRATOR (NAME, ADDRESS, PHONE NO) University of Notre Dame Risk Management & Safety 636 Grace Hall Notre Dame, Indiana 46556 PHONE: 574-631-5037		CARRIER FEDERAL ID#	CHECK IF APPROPRIATE <input checked="" type="checkbox"/> SELF INSURANCE
		<input type="checkbox"/> INSURANCE CARRIER	POLICY/SELF-INSURED NUMBER
		<input type="checkbox"/> THIRD PARTY ADMIN	POLICY PERIOD FROM TO
AGENT NAME		CODE NUMBER	

OCCURRENCE/TREATMENT INFORMATION								
DATE OF INJ/EXP		TIME OF OCCURRENCE ___M		DATE EMPLOYER NOTIFIED		TYPE OF INJURY/EXPOSURE		TYPE CODE
LAST WORK DATE		TIME WORKDAY BEGAN		DATE DISABILITY BEGAN		PART OF BODY		PART CODE
RTW DATE		DATE OF DEATH		INJURY/EXPOSURE OCCURRED ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		CONTACT NAME		PHONE NUMBER
DEPARTMENT OR LOCATION WHERE ACCIDENT/EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS INVOLVED IN ACCIDENT				
SPECIFIC ACTIVITY ENGAGED IN DURING ACCIDENT/EXPOSURE				WORK PROCESS EMPLOYEE ENGAGED IN DURING ACCIDENT/EXPOSURE				
HOW INJURY/EXPOSURE OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY RELEVANT OBJECTS OR SUBSTANCES								CAUSE OF INJURY CODE
NAME OF PHYSICIAN/HEALTH CARE PROVIDER						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/		
WITNESSES (NAME, PHONE #)				DATE ADMINISTRATOR NOTIFIED				
DATE PREPARED		PREPARER'S NAME		TITLE		PHONE NUMBER		

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the shaded areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.
2. Enter all dates in MM/DD/YY format.
3. Please return completed forms to:
Indiana Worker's Compensation Board
402 W. Washington St., Room W196
Indianapolis, IN 46204-2753
4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME & CODE NUMBER: Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and/or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (e.g. Acetylene cutting torch, metal plate, etc.).

AVG WG/WK: Claimant's average weekly wage, calculated by totalling the latest 52 weeks of wages (including overtime, tips, etc.) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME/PHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (i.e. Supervisor, HR Person, Nurse, etc.)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwise deigned by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (e.g. Maintenance, Client's Office, Cafeteria, etc.).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-Time, Apprentice Full-Time, Apprentice Part Time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE or UK).

HOW INJURY/ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION/JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury/illness (e.g. Right forearm, Low Back, etc.).

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02=Updated or Amended First Report.

RTW DATE (Return to Work Date): Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT/EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting).

TYPE OF INJURY/ILLNESS: Briefly describe the nature of the injury or illness (e.g. Contusion, Laceration, Fracture, etc.)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT/EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (e.g. Building maintenance).

