



**State of Connecticut
Workers' Compensation Commission**

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 10-19-2000

FRI

Date filed in Chairman's Office

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

(for WCC use only)

EMPLOYER

Employer (Name, Address & Zip)		Phone #	Carrier / Administrator Claim #	Report Purpose Code
			Jurisdiction	Jurisdiction Claim #
			Employer's Location Address (if different)	Phone #
SIC Code	FEIN			

CARRIER

Carrier (Name, Address & Zip)	Phone #

CLAIMS ADMINISTRATOR

Claims Administrator (Name, Address & Zip)	Phone #

POLICY

Policy / Self-Insured #	<input type="checkbox"/> Check, if Self-Insured	Policy Period (MM/DD/YY) FROM: _____ TO: _____
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EMPLOYEE

Last Name	First Name	Middle Name	Gender
Address (incl. Zip)			<input type="checkbox"/> Male
Phone #			<input type="checkbox"/> Female
Date of Birth (MM/DD/YY)	Social Security #		

WAGE

Date Hired (MM/DD/YY)	State of Hire
Occupation / Job Title	
Rate of Pay \$ _____ . _____ per	NCCI Class Code
<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other	

OCCURRENCE

Date of Injury / Illness (MM/DD/YY)	Town of Injury / Illness
Date Employer Notified (MM/DD/YY)	Did Injury / Illness occur on Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date Disability Began (MM/DD/YY)	Type of Injury / Illness
Date Last Worked (MM/DD/YY)	Part of Body Affected
Date Return(ed) to Work (MM/DD/YY)	Type of Injury / Illness Code
If Fatal, Date of Death (MM/DD/YY)	Part of Body Affected Code
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:	Were Safeguards or Safety Equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If provided, were they used? <input type="checkbox"/> Yes <input type="checkbox"/> No
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:	How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:
Contact Name	Cause of Injury Code
Phone #	

TREATMENT

Physician / Health Care Provider (Name, Address & Zip)
Hospital (Name, Address & Zip)
Initial Treatment
<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Care
<input type="checkbox"/> Minor — by Employer <input type="checkbox"/> Hospitalized More Than 24 Hours
<input type="checkbox"/> Minor — by Clinic / Hospital <input type="checkbox"/> Future Major Medical — Lost Time Anticipated

PREPARER

Date Administrator Notified (MM/DD/YY)	Date Prepared (MM/DD/YY)
Preparer's Name & Title	Phone #