

MWCC - 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					
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #			
SIC CODE	EMPLOYER FEIN			PHONE #			
CARRIER/CLAIMS ADMINISTRATOR							
CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)			
		TO CHECK IF APPROPRIATE SELF INSURANCE					
CARRIER FEIN		POLICY/SELF-INSURED NUMBER				ADMINISTRATOR FEIN	
AGENT NAME & CODE NUMBER							
EMPLOYEE/WAGE							
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH		SOCIAL SECURITY NUMBER			
ADDRESS (INCL ZIP)		SEX <input type="checkbox"/> MALE (M) <input type="checkbox"/> FEMALE (F) <input type="checkbox"/> UNKNOWN (U)	MARITAL STATUS		DATE HIRED		
			<input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U)		OCCUPATION/JOB TITLE EMPLOYMENT STATUS NCCI CLASS CODE		
			<input type="checkbox"/> MARRIED (M) <input type="checkbox"/> SEPARATED (S) <input type="checkbox"/> UNKNOWN (K)				
PHONE		# OF DEPENDENTS					
RATE PER:	DAY WEEK	MONTH OTHER:	#DAYS WORKED WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?	<input type="checkbox"/> YES YES	<input type="checkbox"/> NO NO
OCCURRENCE/TREATMENT							
TIME EMPLOYEE BEGAN WORK	AM PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM 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	
COUNTY 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 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? WERE THEY USED?			<input type="checkbox"/> YES YES	<input type="checkbox"/> NO NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL (NAME & ADDRESS)			INITIAL TREATMENT NO MEDICAL TREATMENT (0) MINOR: BY EMPLOYER (1) MINOR CLINIC/HOSP (2) EMERGENCY CARE (3) HOSPITALIZED > 24 HRS (4) FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED (5)	
WITNESSES (NAME & PHONE #)							
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED		PREPARER'S NAME & TITLE				