

# 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		DATE HIRED	STATE OF HIRE	
ADDRESS (INCL ZIP)			SEX		MARITAL STATUS		OCCUPATION/JOB TITLE		
			<input type="checkbox"/> MALE (M) <input type="checkbox"/> FEMALE (F) <input type="checkbox"/> UNKNOWN (U)		<input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U) <input type="checkbox"/> MARRIED (M) <input type="checkbox"/> SEPARATED (S) <input type="checkbox"/> UNKNOWN (K)		EMPLOYMENT STATUS		
			# OF DEPENDENTS		NCCI CLASS CODE				
PHONE									
RATE		PER:	DAY	MONTH	#DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY?		YES	NO
		WEEK	OTHER:			DID SALARY CONTINUE?		YES	NO

OCCURRENCE/TREATMENT									
TIME EMPLOYEE BEGAN WORK		AM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN	
		PM			PM				
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?				YES	NO
				WERE THEY USED?				YES	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				PHONE NUMBER	