State of Connecticut
Workers' Compensation Commission

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

Rev. 7-13-2009

FRI

Date filed in Chairman's Office

(for WCC use only)

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.

Employer *(Name, Address & Zip)* | Phone #

SIC Code | FEIN

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ☐ Check, if Self-Insured

Policy Period *(MM/DD/YY)* FROM: TO:

Employee: Last Name | First Name | Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender ☐ Male ☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ ____________ . ______ per ☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Town of Injury / Illness

Time Employee Began Work ☐ a.m. ☐ p.m.

Did Injury / Illness occur on Employer's Premises? ☐ Yes ☐ No

Time of Occurrence ☐ cannot be determined ☐ a.m. ☐ p.m.

Type of Injury / Illness

Date Employer Notified *(MM/DD/YY)*

Part of Body Affected

Date Disability Began *(MM/DD/YY)*

Type of Injury / Illness Code

Date Last Worked *(MM/DD/YY)*

Part of Body Affected Code

Date Return(ed) to Work *(MM/DD/YY)*

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

If provided, were they used? ☐ Yes ☐ No

If Fatal, Date of Death *(MM/DD/YY)*

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Contact Name

Phone #

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

☐ No Medical Treatment
☐ Emergency Care
☐ Minor — by Employer
☐ Hospitalized More Than 24 Hours
☐ Minor — by Clinic / Hospital
☐ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN FIELDS MARKED *

DATES:

Enter all dates in MM/DD/YY format.

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.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsibility for administering the claim.

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.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicated the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise deigned by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable in no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process
(eg. walking along a hallway).

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:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance the directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following the most recent disability period on which the employee returned to work.