

# 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                      |                           |                       |
| SIC CODE                           | EMPLOYER FEIN | EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) |                           | LOCATION #<br>PHONE # |

## CARRIER/CLAIMS ADMINISTRATOR

|                                    |                            |   |   |  |
|------------------------------------|----------------------------|---|---|--|
| CARRIER (NAME, ADDRESS & PHONE NO) |                            | POLICY PERIOD<br><br>TO   | CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) |  |
|                                    |                            | <input type="checkbox"/> CHECK IF APPROPRIATE<br>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)         |  | <b>SEX</b>                           |  | <b>MARITAL STATUS</b> |  |
|                            |  | <input type="checkbox"/> MALE (M)    | <input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U) | OCCUPATION/JOB TITLE  |  |
|                            |  | <input type="checkbox"/> FEMALE (F)  | <input type="checkbox"/> MARRIED (M)                   | EMPLOYMENT STATUS     |  |
|                            |  | <input type="checkbox"/> UNKNOWN (U) | <input type="checkbox"/> SEPARATED (S)                 | NCCI CLASS CODE       |  |
| PHONE                      |  | # OF DEPENDENTS                      | <input type="checkbox"/> UNKNOWN (K)                   |                       |  |
| RATE                       | PER: <input type="checkbox"/> DAY <input type="checkbox"/> MONTH | #DAYS WORKED WEEK                    | FULL PAY FOR DAY OF INJURY?                            |                       | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|                            | <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER:    |                                      | DID SALARY CONTINUE?                                   |                       | <input type="checkbox"/> YES <input type="checkbox"/> NO |

## OCCURRENCE/TREATMENT

|   |   |                        |                             |  |                            |                        |                       |
|---|---|------------------------|-----------------------------|--|----------------------------|------------------------|-----------------------|
| TIME EMPLOYEE BEGAN WORK  | <input type="checkbox"/> AM <input type="checkbox"/> PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE          | <input type="checkbox"/> AM <input type="checkbox"/> 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?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |                        | 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?<br>WERE THEY USED? | <input type="checkbox"/> YES <input type="checkbox"/> NO  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS) |                              | HOSPITAL (NAME & ADDRESS)  | <b>INITIAL TREATMENT</b><br>NO MEDICAL TREATMENT (0) <input type="checkbox"/><br>MINOR: BY EMPLOYER (1) <input type="checkbox"/><br>MINOR CLINIC/HOSP (2) <input type="checkbox"/><br>EMERGENCY CARE (3) <input type="checkbox"/><br>HOSPITALIZED > 24 HRS (4) <input type="checkbox"/><br>FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) <input type="checkbox"/> |  |
| WITNESSES (NAME & PHONE #)                      |                              |  |   |  |
| DATE ADMINISTRATOR NOTIFIED                     | DATE PREPARED                | PREPARER'S NAME & TITLE  | PHONE NUMBER  |  |