State of Connecticut
Workers' Compensation Commission

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

Rev. 7-22-2002

FRI

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.

Date filed in Chairman's Office

(for WCC use only)

EMPLOYER

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

Carrier / Administrator Claim # | OSHA Log Case # | 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 # | ❑ Check, if Self-Insured | Policy Period *(MM/DD/YY)* FROM: TO:

EMPLOYEE

Last Name | First Name | Middle Name | Gender ❑ Male ❑ Female

Address *(incl. Zip)* | Phone #

Date of Birth *(MM/DD/YY)* | Social Security #

WAGE

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

Occupation / Job Title

Rate of Pay $ _____ . _____ per ❑ Hour ❑ Day ❑ Week ❑ Bi-Weekly ❑ Other | NCCI Class Code

OCCURRENCE

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

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

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

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

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

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

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

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

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 #

Town of Injury / Illness

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

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ❑ Yes ❑ No

If provided, were they used? ❑ Yes ❑ No

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

Cause of Injury Code

TREATMENT

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

Hospital *(Name, Address & Zip)*

Initial Treatment

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

PREPARER

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

Preparer's Name & Title | Phone #