INDIANA WORKER'S COMPENSATION
FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R9 / 3-01)

Please return completed form electronically by an approved EDI process.

FOR WORKER'S COMPENSATION BOARD USE ONL		
Jurisdiction	Jurisdiction claim number	Process date

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Social Security Number	Date of Birth	Sex	Occupation / Job Title	NCCI class code
		☐ MALE ☐ FEMALE ☐ UNKNOWN		N/A

Name *(last, first, middle)*	Marital status	Date hired	State of hire	Employee status
	☐ UNMARRIED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN		N/A	N/A

Address (number and street, city, state, ZIP code)	Hrs / Day	Days / Wk	Avg Wg / Wk	☐ ~~Paid Day of Injury~~ ☐ ~~Salary Continued~~

Telephone number (include area code)	Number of dependents	Wage	Per
	N/A		☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number
	N/A	N/A	N/A

	Location number N/A	Employer's location address *(if different)*
	Telephone number N/A	N/A

Carrier / Administration claim number	Report purpose code
N/A	N/A

Actual location of accident / exposure (if not on employer's premises)

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate
N/A	N/A	N/A ☐ SELF INSURANCE

Address of claims administrator *(number and street, city, state, ZIP code)*	☐ Insurance Carrier N/A ☐ Third PArty Admin. N/A	Policy / Self-insured number
N/A		N/A
Telephone number N/A		Policy period FROM N/A TO N/A

Name of agent	Code number
N/A	N/A

OCCURRENCE / TREATMENT INFORMATION

Date of Inj. / Exp.	Time of occurrence	Date employer notified	Type of injury / exposure	Type code
	☐ AM ☐ PM			N/A

Last work date	Time workday began	Date disability began	Part of body	Part code
				N/A

RTW date	Date of death	Injury / Exposure occurred on employer's premises?	Name of contact	Telephone number
		☐ YES ☐ NO	N/A	N/A

Department or location where accident / exposure occurred	All equipment, materials, or chemicals
	N/A

Specific activity engaged in during accident / exposure	Work process employee engaged in during accident / exposure
	N/A

How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.

Cause of injury code N/A

Name of physician / health care provider	INITIAL TREATMENT
	☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor: Clinic / Hospital ☐ Emergency Care ☐ Hospitalized > 24 Hours ☐ Future Major Medical / Lost Time Anticipated

Name of witness	Telephone number	Date administrator notified

Date prepared	Name of preparer	Title	Telephone number

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13)