

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 # PHONE #			
SIC CODE		EMPLOYER FEIN									
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 ☐ MALE (M) ☐ FEMALE (F) ☐ UNKNOWN (U)		MARITAL STATUS ☐ UNMARRIED/SINGLE/DIVORCED (U) ☐ MARRIED (M) ☐ SEPARATED (S) ☐ UNKNOWN (K)		OCCUPATION/JOB-TITLE			
								EMPLOYMENT STATUS			
								NCCI CLASS CODE			
PHONE				# OF DEPENDENTS							
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			