ACORD™ 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 #:

PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

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

○ FEMALE

○ UNKNOWN

MARITAL STATUS

○ UNMARRIED SINGLE/DIVORCED

○ MARRIED

○ SEPARATED

○ UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE

PER: ○ DAY ○ WEEK ○ MONTH ○ OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ○ YES ○ NO

DID SALARY CONTINUE? ○ YES ○ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ○ AM ○ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ○ AM ○ 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? ○ YES ○ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION 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 THE 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

○ MINOR: BY EMPLOYER

○ MINOR CLINIC/HOSP

○ EMERGENCY CARE

○ HOSPITALIZED > 24 HRS

○ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

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NOTE TO SUPERVISOR

REMEMBER AN ACCIDENT INVESTIGATION IS NOT DESIGNED TO FIND FAULT OR BLAME. IT IS AN ANALYSIS TO DETERMINE CAUSES THAT CAN BE CONTROLLED OR ELIMINATED.

WHEN COMPLETING THE INVESTIGATION, TRY TO ANSWER THESE QUESTIONS

HOW DID THE ACCIDENT OCCUR?

WHERE DID IT HAPPEN?

WHAT MATERIAL, MACHINES EQUIPMENT OR CONDITIONS WERE INVOLVED

WHO WAS INJURED?

WHEN DID IT HAPPEN?

MAKE RECOMMENDATIONS!

NO INVESTIGATION IS COMPLETE UNLESS CORRECTIVE ACTION IS SUGGESTED

FOLLOW-UP

DETERMINE WHAT ACTION IS BEING TAKEN ON YOUR RECOMMENDATIONS.

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

DATE ______________________________ TIME __________

EMPLOYEE INVOLVED ______________________________ AGE ______

POSITION ____________________ DATE EMPLOYED ______________

SUPERVISOR ____________________ DEPARTMENT ______________

HOW LONG WAS EMPLOYEE PREFORMING THIS OPERATION? __________

WAS THE EMPLOYEE INSTRUCTED ______________________________

DID THE ACCIDENT RESULT IN AN INJURY ______________________

NATURE AND EXTENT OF INJURY

DATE INJURY REPORTED ______________ LOSS OF WORK DAYS ______ (YES OR NO)

IF SO WHEN, AND BY WHOM ______________________________

HOW DID ACCIDENT OCCUR?

CAUSE OF ACCIDEN

RECOMMENDATIONS TO PREVENT A RECURRENCE

WHAT ACTION HAS BEEN TAKEN

SIGNED ____________________ **DEPT** __________ **DATE** __________

SAFETY COMMITTEE COMMENTS

RECOMMENDATIONS

SIGNED ____________________ DEPT __________ DATE __________

EXECUTIVE

SPECIAL ORDERS

SIGNED ____________________ DATE ______________