

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL. ZIP)		CARRIER / ADMINISTRATOR CLAIM NUMBER	OSHA LOG CASE #	REPORT PURPOSE CODE	
		JURISDICTION		JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER			
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)			LOCATION #
INDUSTRY CODE	EMPLOYER FEIN	PHONE #			
CARRIER, CLAIMS, ADMINISTRATOR					
CARRIER (NAME, ADDRESS, & PHONE #)		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE #)		
		CHECK IF APPROPRIATE <input type="checkbox"/> SELF-INSURANCE	AAC Risk Management 1415 West Third Little Rock, AR 72201 Phone: (501) 375-8805		
CARRIER FEIN	POLICY / SELF-INSURED NUMBER			ADMINISTRATOR FEIN	
EMPLOYEE / WAGE					
NAME (LAST, FIRST, MIDDLE INITIAL)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL. ZIP)		SEX M MALE F FEMALE U UNKNOWN	MARITAL STATUS U UNMARRIED SINGLE / DIVORCED M MARRIED S SEPARATED K UNKNOWN	OCCUPATION / JOB TITLE	
		# OF DEPENDENTS		EMPLOYMENT STATUS	
PHONE				NCCI CLASS CODE	
RATE PER:	DAY / WEEK	MONTH / OTHER:	DAYS WORKED / WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?	YES / NO
OCCURRENCE / TREATMENT					
TIME EMPLOYEE BEGAN WORK	AM / PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE () CANNOT BE DETERMINED	AM / PM	LAST WORK DATE
					DATE EMPLOYER NOTIFIED
CONTACT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED	
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> 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 OR OFF SITE TREATMENT (NAME & ADDRESS)		INITIAL TREATMENT	
				0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC / HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL / LOST TIME ANTICIPATED	
OTHER					
WITNESSES (NAME & PHONE #)					
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER	