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

State Form 34401 (R10 / 1-02)

Please return completed form electronically by an approved EDI process.

| FOR WORKER'S COMPENSATION BOARD USE ONLY | | |
|---|---|---|
| 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 ☐ Male ☐ Female ☐ Unknown | Occupation / Job title | NCCI class code |
|---|---|---|---|---|
| | | | | |

| Name (*last, first, middle*) | Marital status ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown | Date hired | State of hire | Employee status |
|---|---|---|---|---|
| | | | | |

| 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 ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other |
|---|---|---|---|
| | | | |

## EMPLOYER INFORMATION

| Name of employer | Employer ID# | SIC code | Insured report number |
|---|---|---|---|
| | | | |

| Address of employer (*number and street, city, state, ZIP code*) | Location number | Employer's location address (*if different*) |
|---|---|---|
| | | |
| | Telephone number | |
| | Carrier / Administrator claim number | OSHA log number / Report purpose code |
| | | |

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 ☐ Self Insurance |
|---|---|---|
| | | |

| Address of claims administrator (*number and street, city, state, ZIP code*) | ☐ Insurance Carrier | Policy / Self-insured number |
|---|---|---|
| | | |
| Telephone number | ☐ Third Party Admin. | Policy period From To |
| | | |

| Name of agent | Code number |
|---|---|
| | |

## OCCURRENCE / TREATMENT INFORMATION

| Date of Inj. / Exp. | Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined | Date employer notified | Type of injury / exposure | Type code |
|---|---|---|---|---|
| | | | | |

| Last work date | Time workday began | Date disability began | Part of body | Part code |
|---|---|---|---|---|
| | | | | |

| RTW date | Date of death | Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No | Name of contact | Telephone number |
|---|---|---|---|---|
| | | | | |

| Department or location where accident / exposure occurred | All equipment, materials, or chemicals involved in accident |
|---|---|
| | |
| Specific activity engaged in during accident / exposure | Work process employee engaged in during accident / exposure |
| | |

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

Cause of injury code

Name of physician / health care provider

Hospital or offsite treatment *(name and address)*

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).*

# INSTRUCTIONS

## General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.
2. Enter all dates in MM/DD/YY format.
3. Please return completed form electronically by an approved EDI process.
4. For answers to questions, please call (317) 232-3808.

## Definitions:

**AGENT NAME & CODE NUMBER:** Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

**ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED:** List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (*e.g. Acetylene cutting torch, metal plate, etc.*).

**AVG WG/WK:** Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc*.) and dividing by 52.

**CLAIMS ADMINISTRATOR:** Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

**CONTACT NAME / PHONE NUMBER:** Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc*.)

**DATE DISABILITY BEGAN:** The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised designated by statute.

**DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED:** If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc*.).

**EMPLOYEE STATUS:** Indicate the employee's work status from the following choices: Full-time, Part-Time, Apprentice Full-Time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as follows*: FT, PT, AFT*, *APT, VO, SW, PW, OS, DI, RE, NE or UK*).

**HOW INJURY / ILLNESS OCCURRED:** Describe the sequence of events leading to the injury or exposure (e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall).

**NCCI CLASS CODE:** A four-digit code classifying the occupation of the claimant.

**OCCUPATION / JOB TITLE:** Enter the primary occupation of the claimant at the time of the accident or exposure.

**PART OF BODY AFFECTED:** Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc*.).

**REPORT PURPOSE CODE:** 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

**RTW DATE (*Return to Work Date*):** Enter the date following the most recent disability period on which the employee returned to work.

**SIC CODE:** This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

**SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE:** Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

**TYPE OF INJURY / ILLNESS:** Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc*.)

**WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE:** Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).