



**State of Connecticut
Workers' Compensation Commission**

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

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Date filed in Chairman's Office

(for WCC use only)

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT in INK.

Employer (Name, Address & Zip)		Phone #	Carrier / Administrator Claim #		OSHA Log Case #	Report Purpose Code
Jurisdiction			Jurisdiction Claim #			
Employer's Location Address (if different)			Phone #			
SIC Code	FEIN					
Carrier (Name, Address & Zip)		Phone #	Claims Administrator (Name, Address & Zip)		Phone #	
Policy / Self-Insured #		<input type="checkbox"/> Check, if Self-Insured		Policy Period (MM/DD/YY) FROM: TO:		
Employee: Last Name		First Name	Middle Name	Gender	Date Hired (MM/DD/YY)	State of Hire
D.O.B. (required)		Phone #		<input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation / Job Title	
Address (incl. Zip)					Rate of Pay \$ _____ per	NCCI Class Code
				<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other		
Date of Injury / Illness (MM/DD/YY)		Town of Injury / Illness		Physician / Health Care Provider (Name, Address & Zip)		
Time Employee Began Work <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Did Injury / Illness occur on Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Hospital (Name, Address & Zip)		
Time of Occurrence <input type="checkbox"/> cannot be determined <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Type of Injury / Illness				
Date Employer Notified (MM/DD/YY)		Part of Body Affected		Initial Treatment <input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Care <input type="checkbox"/> Minor — by Employer <input type="checkbox"/> Hospitalized More Than 24 Hours <input type="checkbox"/> Minor — by Clinic / Hospital <input type="checkbox"/> Future Major Medical — Lost Time Anticipated		
Date Disability Began (MM/DD/YY)		Type of Injury / Illness Code				
Date Last Worked (MM/DD/YY)		Part of Body Affected Code		Date Administrator Notified (MM/DD/YY) Date Prepared (MM/DD/YY)		
Date Return(ed) to Work (MM/DD/YY)		Were Safeguards or Safety Equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No If provided, were they used? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Fatal, Date of Death (MM/DD/YY)		How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:		Preparer's Name & Title Phone #		
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:		Cause of Injury Code				
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:						
Contact Name						
Phone #						