

WC Form 2
Rev. 1-93

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

OMBUDSMAN 1—800—528—5166

Send to: Your workers' compensation insurance carrier, in duplicate

PRINT OR TYPE

EMPLOYER	1. EMPLOYER'S NAME AND MAILING ADDRESS (As shown on Insurance Policy or S.I. Certificate) (No. & Street, City, County, State, ZIP)		LOCATION, IF DIFFERENT FROM MAILING ADDRESS		Do Not Write In The Space Below	
	TELEPHONE NUMBER				Employer U.C. ←	
	2. EMPLOYER IDENTIFICATION (U.C. ACCOUNT) NUMBER		3. CARRIER OR SELF-INSURANCE REGISTRATION NUMBER		Carrier Number ←	
	4. NATURE OF BUSINESS (Manufacturing, Trade, Transportation, etc.)		SPECIFIC PRODUCTS		SIC	
	5. WORKERS' COMPENSATION PROVIDED BY: INSURANCE CARRIER IF INSURANCE CARRIER, GIVE NAME AND ADDRESS:		SELF-INSURANCE	GROUP FUND	Carrier-Fund	
EMPLOYEE	6. EMPLOYEE'S NAME (Last) (First) (Middle)		7. SEX MALE FEMALE	8. AGE	9. SOCIAL SECURITY NO.	
	10. EMPLOYEE'S HOME ADDRESS (No. & Street or RFD, City, County, State, ZIP)		11. MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED		Marital Status	
	12. HOME TELEPHONE	13. REGULAR OCCUPATION		14. WORKING IN WHAT DEPARTMENT WHEN HURT		
					Dependents	
INJURY OR ILLNESS	15. PLACE OF ACCIDENT OR EXPOSURE (Address or location, include County)			16. ON EMPLOYER'S PREMISES? YES NO		
	17. Date of Occurrence	18. TIME OF DAY a.m. p.m.	19. Date Disability Began	20. Date Employer Notified		
	21. DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED. (E.g., amputation of right index finger at second joint, fracture of 2 ribs, lead poisoning, dermatitis of left hand, etc.)					Occupation
	22. IF FATAL, GIVE DATE OF DEATH					Event County
	23. WHAT THING DIRECTLY PRODUCED THIS INJURY OR ILLNESS? (Name object struck against or struck by; vapor, poison, chemical or radiation; if strain or hernia, the thing being lifted, pulled, pushed, etc.; if injury resulted solely from bodily motion, the stretching, twisting, etc. which resulted in injury.)					On Premises
	24. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Begin by telling what the employee was doing just before the accident or exposure. Be specific. If employee was using tools or equipment, or handling material, name them and tell what employee was doing with them.) (Now describe fully the events which resulted in injury or illness. Tell what happened and how it happened. Specify how objects or substances were involved. Give full details of all factors which led or contributed to the accident or exposure.)					Event Date
	25. NAME AND ADDRESS OF TREATING PRACTITIONER					Paid Day Injury
	NAME AND ADDRESS OF HOSPITAL HOSPITALIZED OUT-PATIENT EMERGENCY TREATMENT					Employer Knew
	26. Has Injured Returned to Work? Yes No					Injury Source
	27. If so, Date					Accident Type
28. At What Wage?					Nature of Injury	
29. At What Occupation?					Part of Body	
30. LENGTH OF TIME IN YOUR EMPLOY? Years _____ Months _____					Date of Death	
31. LENGTH OF TIME IN PRESENT JOB Years _____ Months _____					Stopped Work	
32. NUMBER OF DEPENDENTS					Time Employed	
33. Average Weekly Wage					Time in Job	
34. Weekly Value of Remuneration Other Than Wages-(Food, Lodging, etc.)					Weekly Wage	
35. DID EMPLOYEE RECEIVE FULL PAY FOR DAY OF INJURY? YES NO					Report Date	
36. Date of This Report					Report Received	
37. Signed by					Back to Work	
38. Signature					Case Class	
39. Official Position or Title						