



**State of Connecticut  
Workers' Compensation Commission**

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

Rev. 7-22-2002

**FRI**

Date filed in Chairman's Office

**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.

*(for WCC use only)*

**EMPLOYER**

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**

Carrier (Name, Address & Zip)	Phone #

**CLAIMS ADMINISTRATOR**

Claims Administrator (Name, Address & Zip)	Phone #

**POLICY**

Policy / Self-Insured #	<input type="checkbox"/> Check, if Self-Insured	Policy Period (MM/DD/YY) FROM: _____ TO: _____
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**EMPLOYEE**

Last Name	First Name	Middle Name	Gender
Address (incl. Zip)			<input type="checkbox"/> Male
Phone #			<input type="checkbox"/> Female
Date of Birth (MM/DD/YY)	Social Security #		

**WAGE**

Date Hired (MM/DD/YY)	State of Hire
Occupation / Job Title	
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	

**OCCURRENCE**

Date of Injury / Illness (MM/DD/YY)	Town of Injury / Illness
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
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
Date Disability Began (MM/DD/YY)	Type of Injury / Illness Code
Date Last Worked (MM/DD/YY)	Part of Body Affected Code
Date Return(ed) to Work (MM/DD/YY)	Were Safeguards or Safety Equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Fatal, Date of Death (MM/DD/YY)	If provided, were they used? <input type="checkbox"/> Yes <input type="checkbox"/> No
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:	How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:	
Contact Name	
Phone #	Cause of Injury Code

**TREATMENT**

Physician / Health Care Provider (Name, Address & Zip)
Hospital (Name, Address & Zip)
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

**PREPARER**

Date Administrator Notified (MM/DD/YY)	Date Prepared (MM/DD/YY)
Preparer's Name & Title	Phone #