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ALL COPIES OF FIRST REPORT MUST BE TYPED OR PRINTED

Department of Labor
Office of Workers' Compensation
P.O. Box 8902
Wilmington, DE 19899-8902
Telephone 302-761-8200

STATE OF DELAWARE
FIRST REPORT
OF
OCCUPATIONAL INJURY
OR DISEASE

CASE OR FILE NO.

EMPLOYER'S UC REPORTING NUMBER

EMPLOYEE

1. EMPLOYEE: FIRST / MIDDLE / LAST			2. EMPLOYEE SOCIAL SECURITY NO.
3. ADDRESS - INCLUDE COUNTY AND ZIP CODE		4. MALE ☐ FEMALE ☐	5. EMPLOYEE TELEPHONE NUMBER (INCLUDE AREA CODE) ( )
6. DATE OF BIRTH	7. AGE	8. WAGE (SEE COMPUTATION ON BACK)	9. WEEKLY HOURS WORKED
10. OCCUPATION (REGULAR)	11. DEPARTMENT OR DIVISION REGULARLY EMPLOYED		12. HOW LONG EMPLOYED

EMPLOYER

13. EMPLOYER	14. PERSON MAKING OUT THIS REPORT	
15. ADDRESS - INCLUDE COUNTY AND ZIP CODE		16. EMPLOYER TELEPHONE NUMBER (INCLUDE AREA CODE) ( )
17. MAILING ADDRESS - IF DIFFERENT THAN ABOVE	18. NATURE OF BUSINESS - TYPE OR MFG., TRADE, CONSTRUCTION, SERVICE, ETC.	

DATES

19. DATE OF REPORT	20. DATE OF INJURY AND TIME Time: ☐ AM ☐ PM Date:	21. NORMAL STARTING TIME ☐ AM ☐ PM	22. IF EMPLOYEE BACK TO WORK GIVE DATE:	23. AT SAME WAGE YES ☐ NO ☐
24. IF FATAL INJURY, GIVE DATE OF DEATH.	25. DATE EMPLOYER KNEW OF INJURY.	26. DATE DISABILITY BEGAN.	27. LAST FULL DAY PAID - DATE	

INJURY OR DISEASE

28. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.

29. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.

OCCURRENCE

30. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE WAS USING WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.

31. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, I.E.

32. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED.

33. NAME OF PHYSICIAN	34. PHYSICIAN'S ADDRESS
35. HOSPITAL (IF APPLICABLE)	36. HOSPITAL ADDRESS

WORKER'S COMPENSATION INSURANCE COMPANY AND COMPLETE ADDRESS (PREPRINT OR STAMP INCLUDE IAB CODE)
37. (THIS SECTION MUST BE COMPLETED IN ORDER TO PROCESS.)

POLICY NO.

DISTRIBUTION OF THIS REPORT

1. **ORIGINAL MUST BE SENT IMMEDIATELY TO WORKER'S COMPENSATION INSURANCE CARRIER.**
2. **COPY TO THE INDUSTRIAL ACCIDENT BOARD**
3. **EMPLOYER'S COPY - RETAIN AS RECORD**
4. **EMPLOYEE'S COPY**

SIGNATURE OF PERSON IN 14 ABOVE

OFFICAL POSTION