SOUTH DAKOTA EMPLOYER'S FIRST REPORT OF INJURY

(SEE INSTRUCTIONS ON BACK OF FORM)

EMPLOYEE INFORMATION

1 Social Security Number

2 Date of Injury

3 Date of Birth

4 Last Name, First Name, Middle Initial

5 Education (check one) ☐ Less than High School ☐ GED or High School ☐ Beyond High School

6 Home Address

7 Sex (check) ☐ Male ☐ Female

8 Dependents

9 City, State, Zip Code

10 Telephone Number

11 Position Title

12 Employment Type (check) ☐ Regular ☐ Temporary

13 Employment Status (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer

14 Current Wage

$ ________________ per ________________

15 Hours Per Week

16 Time in Current Position

17 Date Hired

INJURY INFORMATION

18 Injury Description (select codes from the back of form for the following)

A. Body Part Injured ☐☐ B. Cause of Injury ☐☐ C. Nature of Injury ☐☐

Describe Injury Below

____

____

19 Address or Location of Injury

20 Time of Injury ☐ AM ☐ PM

21 Time Work Day Began ☐ AM ☐ PM

22 Date Employer Notified

23 Reported to

24 Witness

25 Return to Work Date

26 Date of Fatality

27 Safety Equipment Provided? Yes or No

Was Safety Equipment Used? Yes or No

28 Doctor, Clinic, or Hospital Name (if treated)

29 Telephone Number

30 Address

31 Type of Treatment (check one) ☐ No Treatment ☐ On-site Treatment ☐ Clinic ☐ Emergency Room ☐ Hospitalization

32 City, State, Zip Code

33 Employee's Signature ________________ Date ________________

EMPLOYER INFORMATION

34 Federal Identification Number

35 Number of Employees

36 Type of Business

37 Business Name

38 Telephone Number

39 Address

40 Date Mailed to Insurance Company

41 City State, Zip Code

42 Form Completed by

43 Employer's Signature ________________ Date ________________

INSURANCE INFORMATION

44 NAIC Number

45 Insurance Claim Office

46 Telephone Number

47 Address

48 Insurance Adjuster

49 City, State, Zip Code

50 Insurance Claim Number

51 Policy Number and Effective Dates

52 Date Insurer Mailed to DOL

GENERAL INSTRUCTIONS

EMPLOYEE:

1. Notify employer immediately of injury.
2. Complete all questions in the employee information and injury information sections.
3. Sign the form.
4. Submit this form to your employer within three (3) business days after the injury.

EMPLOYER:

1. Complete all questions in the employer information section.
2. Sign the form.
3. Submit this form to your workers' compensation insurance carrier within seven (7) days of knowledge of the occurrence of an injury.
4. Give a copy of the form to the injured employee.
5. Keep a copy of the First Report of Injury for at least four years form the date of injury as required by SDCL 62-6-1.

INSURER:

1. Complete all question in the insurance information section at the bottom of the page.
2. Submit this form within ten (10) days of receipt to: South Dakota Department of Labor
Division of Labor and Management
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3681

CODES FOR QUESTIONS #18

18A. Body Part Codes:

30 = Ankle	02 = Finger (index)	33 = Hip	01 = Thumb
09 = Arm	05 = Finger (little)	14 = Knee	06 = Toe (greater)
18 = Back	03 = Finger (second)	13 = Leg	07 = Toe (other)
35 = Chest	04 = Finger (third)	29 = Lungs	10 = Wrist
16 = Ear (one)	12 = Foot	25 = Mouth	23 = Multiple Injury
17 = Ears (both)	34 = Groin	27 = Neck	24 = Other
11 = Elbow	08 = Hand	31 = Ribs/Side	
15 = Eye	26 = Head	28 = Shoulder	
36 = Face	21 = Heart	32 = Stomach	

18B. Cause of Injury Codes:

11 = Bending/Lifting	01 = Motor Vehicle
08 = Body Reaction/Over Reaction	10 = Repetitive Use
06 = Caught In/Under/Between	12 = Stress
03 = Fall From Elevation	05 = Struck Against
04 = Fall From Same Level	07 = Struck By
09 = Hostile Attack	02 = Temperature Extremes
14 = Knife/Sharp Object	13 = Other
15 = Machinery/Equipment	

18C. Nature of Injury Codes:

01 = Allergy	03 = Hearing Loss	05 = Not Applicable
02 = Disfigurement	04 = Occupational Disease	