SAMPLE

Indiana Worker's Compensation
First Report of Employee Injury/Illness

Please Return Completed Form to: 402 W Washington St., Room W196
Indianapolis, IN 46204-2753
(317) 232-3808

FOR WORKER'S COMPENSATION BOARD USE ONLY		
JURISDICTION	JURISDICTION CLAIM NUMBER	PROCESS DATE

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Field	Value
SOCIAL SECURITY NUMBER	331-36-4060
DATE OF BIRTH	1-01-50
SEX	(X) MALE ( ) FEMALE ( ) UNKNOWN
OCCUPATION/JOB TITLE	Custodian
NCCI CLASS CODE	
LAST NAME / FIRST / MIDDLE	Smith, Charles
MARITAL STATUS	( ) UNMARRIED (X) MARRIED ( ) SEPARATED ( ) UNKNOWN
DATE HIRED	7-1-91
STATE OF HIRE	IN
EMPLOYEE STATUS	Full Time
ADDRESS (INCL ZIP)	1234 Main Street Anytown, IN 46662
HRS/DAY	8
DAYS/WK	5
AVG WG/WK	
PAID DAY OF INJ	[X]
SALARY CONT'D	[ ]
PHONE	812-952-1447
# OF DEPENDENTS	3
WAGE	$ 18.00
PER	(X) HR ( ) DAY ( ) WK ( ) MO ( ) YR ( ) OTHER:

EMPLOYER INFORMATION

Field	Value
EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP)	St. Thaddeus Parish 103 Washington Street Anytown, IN 46662
EMPLOYER FEDERAL ID#	
SIC CODE	
INSURED REPORT NUMBER	
LOCATION #	40
PHONE #	812-952-1449
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
CARRIER/ADMINISTRATOR CLAIM NUMBER	
REPORT PURPOSE CODE	
Actual Location of Accident/Exposure (if not on employer's premises):	

CARRIER/CLAIMS ADMINISTRATOR INFORMATION

Field	Value
CLAIMS ADMINISTRATOR (NAME, ADDRESS, PHONE NO)	Gallagher Bassett Services Attn: Jerry Pachciarz 5775 Nimtz Parkway, Suite 100 South Bend, IN 46628 PH 317-572-1321
CARRIER FEDERAL ID#	
CHECK IF APPROPRIATE	[ ] SELF INSURANCE
	[ ] INSURANCE CARRIER
	[X] THIRD PARTY ADMIN
POLICY/SELF-INSURED NUMBER	
POLICY PERIOD	FROM TO
AGENT NAME	Jerry Pachciarz
CODE NUMBER	

OCCURRENCE/TREATMENT INFORMATION

Field	Value
DATE OF INJ/EXP	8-6-01
TIME OF OCCURRENCE	11:00 AM
DATE EMPLOYER NOTIFIED	8-6-01
TYPE OF INJURY/EXPOSURE	Muscle Strain
TYPE CODE	
LAST WORK DATE	8-6-01
TIME WORKDAY BEGAN	8:00 AM
DATE DISABILITY BEGAN	8-6-01
PART OF BODY	Back
PART CODE	
RTW DATE	
DATE OF DEATH	
INJURY/EXPOSURE OCCURRED ON EMPLOYER'S PREMISES?	[ ] YES [ ] NO
CONTACT NAME	
PHONE NUMBER	
DEPARTMENT OR LOCATION WHERE ACCIDENT/EXPOSURE OCCURRED	Cemetery
ALL EQUIPMENT, MATERIALS, OR CHEMICALS INVOLVED IN ACCIDENT	Using Back Hoe
SPECIFIC ACTIVITY ENGAGED IN DURING ACCIDENT/EXPOSURE	Operating Back Hoe
WORK PROCESS EMPLOYEE ENGAGED IN DURING ACCIDENT/EXPOSURE	Digging Hole
HOW INJURY/EXPOSURE OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY RELEVANT OBJECTS OR SUBSTANCES	Employee operating machine when it struck a root jarring his back.
CAUSE OF INJURY CODE	
NAME OF PHYSICIAN/HEALTH CARE PROVIDER	Methodist HOspital Immediate Care
WITNESSES (NAME, PHONE #)	Father Brown
DATE ADMINISTRATOR NOTIFIED	8-6-01
DATE PREPARED	8-7-01
PREPARER'S NAME	L. Smith
TITLE	Parish Secretary
PHONE NUMBER	812-952-1449

INITIAL TREATMENT

- [ ] NO MEDICAL TREATMENT
- [ ] MINOR: BY EMPLOYER
- [ ] MINOR: CLINIC/HOSP
- [ ] EMERGENCY CARE
- [ ] HOSPITALIZED >24 HRS
- [ ] FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13)

STATE FORM 34401 (R8 2/96)