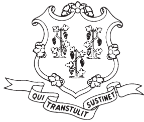

State of Connecticut
Workers' Compensation Commission

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

Rev. 7-13-2009

FRI

Date filed in Chairman's Office

(for WCC use only)

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.

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 *(Name, Address & Zip)*	Phone #	Claims Administrator *(Name, Address & Zip)*	Phone #

Policy / Self-Insured #	❑ Check, if Self-Insured	Policy Period *(MM/DD/YY)* FROM: TO:

Employee: Last Name First Name Middle Name	Gender	Date Hired *(MM/DD/YY)*	State of Hire
D.O.B. *(required)* / Phone #	❑ Male	Occupation / Job Title	
Address *(incl. Zip)*	❑ Female	Rate of Pay $ ________ . ____ per ❑ Hour ❑ Day ❑ Week ❑ Bi-Weekly ❑ Other	NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*	Town of Injury / Illness	Physician / Health Care Provider *(Name, Address & Zip)*
Time Employee Began Work ❑ a.m. ❑ p.m.	Did Injury / Illness occur on Employer's Premises? ❑ Yes ❑ No	
Time of Occurrence ❑ cannot be determined ❑ a.m. ❑ p.m.	Type of Injury / Illness	
Date Employer Notified *(MM/DD/YY)*	Part of Body Affected	Hospital *(Name, Address & Zip)*
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? ❑ Yes ❑ No If provided, were they used? ❑ Yes ❑ No	
If Fatal, Date of Death *(MM/DD/YY)*	How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:	Initial Treatment ❑ No Medical Treatment ❑ Emergency Care ❑ Minor — by Employer ❑ Hospitalized More Than 24 Hours ❑ Minor — by Clinic / Hospital ❑ Future Major Medical — Lost Time Anticipated
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:		Date Administrator Notified *(MM/DD/YY)* / Date Prepared *(MM/DD/YY)*
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:		Preparer's Name & Title / Phone #
Contact Name Phone #	Cause of Injury Code	