SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION

DIVISION OF LABOR AND MANAGEMENT

Tel: 605.773.3681 dlr.sd.gov

FIRST REPORT OF INJURY

GENERAL INSTRUCTIONS

EMPLOYEE

1. Notify employer immediately of injury, as required by SDCL 62-7-10.
2. Complete all questions in the EMPLOYEE and INJURY/TREATMENT 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/EMPLOYMENT sections.
2. Sign the form.
3. Submit this form to your workers' compensation insurance carrier within seven (7) days of knowledge of the occurrence of the injury, as required by SDCL 62-6-2.
4. Give a copy of the form to the injured employee.
5. Keep the copy of the First Report of Injury for at least four (4) years from the date of injury, as required by SDCL 62-6-1.

BODY PART CODES

02	Blindness one eye	44	Chest, including ribs sternum, soft ribs	78	Ring finger at metacarpal bone
03	Blindness both eyes	48	Internal organs-other than heart, lungs	79	Ring finger at proximal joint
04	Deafness both ears	49	Heart	80	Ring finger at middle joint
05	Deafness one ear	51	Hip	81	Ring finger at distal joint
10	Multiple head injury	52	Upper leg	82	Little finger at metacarpal bone
11	Skull	53	Knee	83	Little finger at proximal joint
12	Brain	54	Lower leg	84	Little finger at middle joint
13	Ear(s)	55	Ankle	85	Little finger at distal joint
14	Eye(s)	56	Foot	86	Great toe metatarsal bone
17	Mouth	57	Toe (other than greater)	87	Great toe at proximal joint
19	Face (facial bones)	58	Toe (greater)	88	Great toe at distal joint
20	Multiple neck injury	60	Lungs	90	Multiple injury
21	Vertebrae	61	Groin	92	Other toe metatarsal bone
22	Disc	67	Thumb metacarpal bone	93	Other toe at proximal joint
24	Other	68	Thumb at proximal joint	94	Other toe at middle joint
31	Upper arm	69	Thumb at distal joint	95	Other toe at distal joint
32	Elbow	70	Index finger at metacarpal bone	96	Little toe metatarsal bone
33	Lower Arm-forearm	71	Index finger at proximal joint	97	Little toe at distal joint
34	Wrist	72	Index finger at middle joint		
35	Hand	73	Index finger at distal joint		
37	Thumb	74	Middle finger at metacarpal bone		
38	Shoulder	75	Middle finger at proximal joint		
41	Upper Back	76	Middle finger at middle joint		
42	Lower Back	77	Middle finger at distal joint		

Cause of Injury Codes

01	Body reaction/over reaction (includes chemicals)	70	Striking against or stepping on
03	Temperature extremes	78	Struck or injured by moving parts of machine
13	Caught in/under/between	81	Struck or injured, includes knife or sharp object, kicked, bit, etc. – struck by object, worker, patient, etc.
25	Fall from elevation	89	Hostile attack-person in act of crime
29	Fall from same level	90	Other than physical cause of injury
50	Motor vehicle	94	Repetitive motion – callous, blister, etc.
56	Bending/Lifting	97	Repetitive motion-carpal tunnel syndrome, etc.
65	Machinery/Equipment	99	Other

Nature of injury codes

00	Not applicable
01	Allergy
02	Disfigurement
71	Occupational disease
72	Hearing loss

South Dakota Employer's First Report of Injury

EMPLOYEE

SSN: **Date of Birth:** **Gender: M** ☐ **F** ☐ **Dependents:**

Name: **(Last)** **(First)** **(Middle initial)**

Mailing Address:

City: **State:** **Zip:** **Telephone No.:**

Employee signature: (X) _____ **Date**_____

Education:

☐ **Less than High School**

☐ **GED or High School**

☐ **Beyond High School**

INJURY/TREATMENT

Date of Injury: **Time of Injury:** **a.m.** ☐ **p.m.** ☐ **Fatality Date (if applicable):**

County Where Injury Occurred: **Was Safety Equipment Provided? Yes or No**

Time Work Day Began on Date of Injury: **a.m.** **p.m.** **Was Safety Equipment Used? Yes or No** ☐

Date Returned to Work (if applicable): **Did Injury Occur on Employer Premises? Yes or No**

Address or Location of Injury:

Description of Injury:

Date Employer Notified of Injury:

Injury Reported to: **Witness:**

(See Codes on Second Page)

Body Part Injured

(If code 90, Multiple Injury, please specify body part codes for each body part injured.)

Nature of Injury

Cause of Injury

Type of Treatment (please check one)

☐ **No Treatment**

☐ **On-Site Treatment**

☐ **Clinic**

☐ **Emergency Room**

☐ **Hospitalization**

If treatment sought, please specify provider of treatment:

Mecical Practitioner, Clinic or Hospital Name:

Mailing Address:

City: **State** **Zip**

Telephone No. :

EMPLOYER/EMPLOYMENT INFORMATION:

Federal ID No.: **# Employees:**

Employer Name (DBA):

Mailing Address:

City: **State:** **Zip:**

Telephone No. : **County Where Employer Located:**

Employer signature: _____ **Date**_____

Employment Type: ☐ **Regular or** ☐ **Temporary**

Emp. Status: ☐ **FT** ☐ **PT** ☐ **Seasonal** ☐ **Volunteer**

Date Employee Hired:

Employee's Position:

Employee's Time in Current Position:

Employee's Hours Per Week:

Employee's Current Wage:

$ **per**

CLAIM OFFICE INFORMATION

NAICS for Employer Being Insured (Nature of Business):

Carrier Code **FEIN (Claim Office)**

Claim Office

Claim Office Address

City **State** **ZipCode**

Telephone

Email Address **T**

Claim Office Claim #

Date Notified **Date to DOL**

☐ **Check if Claim Office is same as Insurance Provider**

If not, you must complete the following
UNDERLYING INSURANCE PROVIDER INFORMATION

Carrier Code (If applicable) **FEIN (Insurance Provider)**

Represented Entity Name

Address

City **State** **Zip Code**

Telephone Number

Policy Number

Effective Dates

Adjuster/Contact Person

For information regarding the Workers' Compensation System please visit www.sdjobs.org

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