First Report of Injury

1. EMPLOYEE SOCIAL SECURITY NO:

2. DATE OF CLAIMED INJURY:

Minnesota Department of Labor and Industry
Worker's Compensation Division
443 Lafayette Road North
St. Paul, MN 55155-4306
(651)-284-5020

EMPLOYEE

3. Name (last, first, middle)	4. Time of day of injury:	5. Gender:
6. Home Address (include county and zip) Apt.	7. Time employee began work:	
	8. Date of Birth:	
9. Occupation:	10. Marital Status:	11. Apprentice
12. Regular Dept	13. Home Phone No. (A/C, No.)	14. Date Hired:

15. Average wage/week Remarks	16. Rate per hour	17. Hours per day	18. Days per week

19. What is the weekly value of MEALS: LODGING: 2nd INCOME:

20. Employment Status: (attach 26 week wage statement for parttime or irregularly scheduled employee)

OCCURRENCE

21. PLACE (Include dept & full address)	22. Date of first day of lost time:	23. Date employer notified of injury:
	24. Return to work date:	25. Date employer notified of lost time:
On employer's premises? ○ *Yes* ○ *No*	26. Date of death:	27. OSHA Case #:

28. DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURRED WITH DETAILS OF HOW EVENT OCCURRED (Include name(s) of other individuals involved, tools, machinery, objects, vapors, chemicals, radiations, unnatural motions of employee)

29. DESCRIBE NATURE OF INJURY OR ILLNESS, BE SPECIFIC (Include part(s) of body affected, e.g. amputation of right index finger at second joint, fractured arm, lead poisoning)	30. What tools, equipment, machines, objects or substances were involved? (Examples: chlorine, hand sprayer, pallet lift gate, computer keyboard)

31. PHYSICIAN (Full name, title, address and phone number)	32. HOSPITAL/CLINIC (Name and address)	33. Emergency room used? ○ *Yes* ○ *No*
Physician Telephone:		34. Overnight In-Patient Care? ○ *Yes* ○ *No*

EMPLOYER

35. Legal name & mailing address incl. zip code	36. Date form completed:	37. Unemploment ID No.:	38. NAICS Code
	39. Witnesses and phone numbers		
	40. Employer's Representative, print full name. title, and phone number:		

INSURANCE

41. Insurer ID No:	42. Claim Administrator Claim #:	43. Third Party Administrator ID #:
44. Insurer	45. Date insurer received notice:	46. Third Party Administrator: (Name & Address)