

CAMPUS - WHAT TO DO WHEN THERE IS AN INJURY ON THE JOB

*For Emergencies please direct employee to nearest Emergency Room or Clinic. If possible ensure Employee leaves with **Verification of Employment for Reported WC Claim** (Page 2) **Optum First Fill® Card** (Page 3 & 4) and contact Benefits Department immediately*

- ☐ You must ensure a **First report of Injury** is completed with or with or without the employee's assistance! Go to [this link](http://www.tasbrmf.org) at www.tasbrmf.org and complete **First Report of Injury** and file no later than the next business day. You do not need to log in to complete the First Report of Injury. (Complete with as much information as you have, see instructions on pages 9-17)
- ☐ Have the employee sign **Acknowledgement of Medical Alliance** (Pages 5 & 6)
- ☐ If Employee feels he/she may seek medical treatment complete and give the **Verification of Employment for Reported WC Claim**(Page 2) and **Optum First Fill® Card**(Page 3 & 4)
- ☐ Have Employee advise whether he/she wishes to use available leave for any possible lost time due to the on the job injury by completing and signing an **Election of Leave** form. (Page 7 & 8)

Email or Fax all signed forms and paperwork by the next business day to:

Kimberly Kempken, Benefits and Leave Specialist
Phone: 281.996.6605
Fax: 281.996.2606
Email: kkempken@fisd12.net

Please refer injured employee directly to Benefits for any further questions or issues regarding any workers' compensation injury. Alert Kimberley Kempken immediately if employee misses any time, returns to work, or if there are any questions or concerns.

To search for primary care physicians in your area go to [the Find A Doctor link](#) at the Political Subdivision Medical Alliance www.pswca.org website.

NOTE: A First Report of Injury must be filed once employee reports or campus is made aware of any on the job injury, illness or incident. Group Insurance does not cover medical treatment for compensable workers' compensation injury. Employees should not pay for medical treatment for a workers' compensation injury.



Verification of Employment for a Reported Workers' Compensation Injury or Illness

Please take this form to the doctor for your first medical examination.

Employee Name _____ Date of Injury _____

Date of Birth _____ Social Security _____

Reported Work Related Injury or Illness:

Friendswood ISD workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance.) For emergencies, an injured employee may go to the nearest emergency room. Otherwise, all other treatment must be from an Alliance Provider listed at pswca.org.

Please submit all claim and medical billing information to:

TASB Risk Management Fund
P.O. Box 2010
Austin, TX 78768-2010
Phone: 800.482.7276
Fax: 800.580.6720

Pre-Authorization

Phone: 800.482.7276, x9907
Fax: 888.777.8272

Issuing Signature _____

Title _____

Phone Number _____

Date _____

Providers please submit Work Status Reports and all Job Description enquiries to:

Kimberly Kempken, Benefits and Leave Specialist
Phone: 281.996.6605
Fax: 281.996.2606
Email: kkempken@fisd12.net

For a full list of Alliance Providers please visit pswca.org.

MAKING IT EASY... TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:



If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.



If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.




Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?



1-866-599-5426



WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

CARRIER/TPA

EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk 1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP			

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.



Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:



Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.



Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.




La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?

¿Necesita ayuda?



1-866-599-5426



WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

PORTADORA

EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Por favor provea directamente al farmacéutico

NUMERO DE SEGURO SOCIAL

FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP			

NOTA: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.



Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

Employee Acknowledgement of the Alliance Direct Contracting Program

I have received information that tells me how to get health care under my employer's workers' compensation coverage. If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the Alliance list of doctors designated as treating doctors.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go to any licensed medical professional within the United States.
3. Even though my treating doctor should refer me to a specialist of providers contracted with the Alliance, I understand that I need to verify that the referral doctor is a member of the Alliance provider panel.
4. The Texas Association of School Boards Risk Management Fund will pay the treating doctor and other Alliance providers for all health care related to my compensable injury.
5. I understand that my medical and/or income benefits may be disputed if I receive health care from a provider other than an Alliance provider without prior approval from the Fund.
6. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.
7. If I want to change doctors after my first choice, I can do so within the first 60 days of starting treatment, and I can only choose from the Alliance list of providers. A third choice requires approval from my adjuster.

Signature

____/____/_____
Date

Printed Name

I live at: _____
Street Address City, State, Zip Code

Name of Employer: _____
Name of Direct Contracting Program: Political Subdivision Workers' Compensation Alliance (the Alliance)

Direct contracting service areas are subject to change. To locate a treating doctor within your area, visit the PSWCA web site at pswca.org or call your adjuster at 800.482.7276.

To be completed by the employer only

Please indicate whether this is the:

- ☐ Initial Employee Notification
☐ Injury Notification (Date of Injury: ____/____/____)

Do not return this form to the TASB Risk Management Fund unless requested.



Reconocimiento Del Empleado Para El Programa De Contratar Directamente Con Medicos

He recibido la informacion que explica como obtener tratamientos medicos si me lastimo en el trabajo. Si estoy lastimado en el trabajo y vivo en un área de servicio descrita en esta información, entiendo que:

1. Tengo que escoger un doctor de la lista de la Alliance (PSWCA), que son señalados para tratar.
2. Debo ir a este doctor para todo el tratamiento médico para mi lesión. Si necesito un especialista, el doctor que me trata me referirá. Si necesito tratamientos de emergencia, yo entiendo que puedo ir a cualquier profesional médico licenciado dentro de los Estados Unidos.
3. Si el doctor me refiere a un especialista, yo entiendo que necesito verificar que el doctor sea un miembro del la Alliance.
4. TASB le pagara al doctor escogido y a doctores tambien que son partidos de PSWCA.
5. Puedo ser responsable de la cuenta si recibo tratamiento medico de doctores que no son miembros de la Alliance y sin la aprobacion anterior de TASB.
6. Reportando un reclamo de lastimaduara falsa o fraudulenta es un crimen que puede resultar en multas y o al encarcelamiento.
7. Si deseo cambiar doctores despues de mi primera opción, puedo hacerlo dentro 60 dias de comensar mi tratamieto. Puedo solamente escoger de la lista de doctores que estan en el Alliance. La tercer opción necesita probacion de mi ajustador antes de cabiar doctor.

Firma (Signature)

_____/_____/_____
Fecha (Date)

Nombre en imprenta (Printed Name)

Direccion de domicilio incluyendo ciudad, estado y zip (Address)

Nombre de empleo (Name of Employer): _____

Nombre del programa de contratar doctores directament (Name of Direct Contracting Program):
Political Subdivision Workers' Compensation Alliance (the Alliance)

El servicio de contratar doctores directamente en las areas de servicio, son subjetivos a cambiar. Para localizar un doctor de tratamiento en su area, visite al Internet en:
www.pswca.org o llame a su ajustador al numero: 800.482.7276.

To be completed by the employer only

Please indicate whether this is the:

- ☐ Initial Employee Notification
☐ Injury Notification (Date of Injury:_____/_____/_____)

Do not return this form to the TASB Risk Management Fund unless requested.



**FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION
(NO OFFSET—ENGLISH VERSION)**

Name _____ Employee number _____

Position _____ Department/Campus _____

This employee is absent from duty because of a job-related illness or injury beginning on (*date of first absence attributable to illness or injury*). If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

District authorized signature

Date

Employee choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on **paid** leave and/or family and medical leave (FMLA). I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave that is not FMLA leave. I choose the following option:

- ☐ I choose to use only _____ days of available paid leave at this time.
- ☐ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or -injury wage.
- ☐ I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Friendswood ISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will receive only workers' compensation wage benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

Employee signature

Date

For Claims Reporting Purposes Only:

For all employees:

Amount of leave paid to employee: \$ ____.

Daily rate: \$ _____

Period of payment: from ____/____/____ through ____/____/____
for ____ days **or** ____ weeks

For hourly employees only:

Hourly rate: \$ ____.

Number of hours paid: _____



**FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION
(NO OFFSET—SPANISH VERSION)**

Nombre _____ Número de empleado _____

Posición _____ Departamento/campus _____

Este empleado está ausente de su trabajo debido a una enfermedad o lesión relacionada con el trabajo que comenzó en (fecha de la primera ausencia que se atribuye a enfermedad o lesión). Si es elegible, el seguro de compensación de los trabajadores puede comenzar a pagar un porcentaje de los salarios actuales del empleado en el octavo día de ausencia del trabajo, en caso de que se requiera una ausencia prolongada.

Firma autorizada de distrito

Fecha

Elección del empleado:

Estoy ausente del trabajo debido a una enfermedad o lesión relacionada con el trabajo. Comprendo que no soy elegible para los beneficios de ingreso semanales de compensación para trabajadores hasta que mi ausencia exceda los siete días calendario. También comprendo que el distrito continuará pagando su aporte hacia el costo de mi cobertura de seguros médicos (si es aplicable) siempre y cuando estoy en licencia **con goce de sueldo** y/o licencia familiar o médica (FMLA). Asimismo, comprendo que seré responsable de pagar todas las primas de seguros médicos si estoy en licencia **sin goce de sueldo** que no sea una licencia FMLA. Elijo la siguiente opción:

- ☐ Elijo utilizar solamente _____ días de licencia disponible con goce de sueldo en esta oportunidad.
- ☐ Elijo utilizar todas las licencias con goce de sueldo disponibles. Comprendo que no recibiré los beneficios de ingresos semanales de compensación de los trabajadores hasta que haya acabado toda mi licencia con goce de sueldo o hasta en que la licencia con goce de sueldo no es equivalente a mi sueldo previo a la enfermedad o a la lesión.
- ☐ Elijo **no** utilizar la licencia con goce de sueldo disponible en esta oportunidad. Comprendo que no recibiré pagos de salario regulares de Friendswood ISD mientras reciba los beneficios de ingreso semanales conforme a la compensación de los trabajadores. No se deducirá la licencia con goce de sueldo disponible de mi saldo de licencia. Asimismo, comprendo que, al seleccionar esta opción, recibiré solamente los beneficios de salario de compensación de los trabajadores para las ausencias que deriven de mi enfermedad o lesión relacionada con el trabajo, a menos y hasta que comunique al distrito un cambio en mi decisión.

Firma del empleado

Fecha

For Claims Reporting Purposes Only:

For all employees:

Amount of leave paid to employee: \$ ____.

Daily rate: \$ _____

Period of payment: from ____/____/____ through ____/____/____ for
_____ days **or** _____ weeks

For hourly employees only:

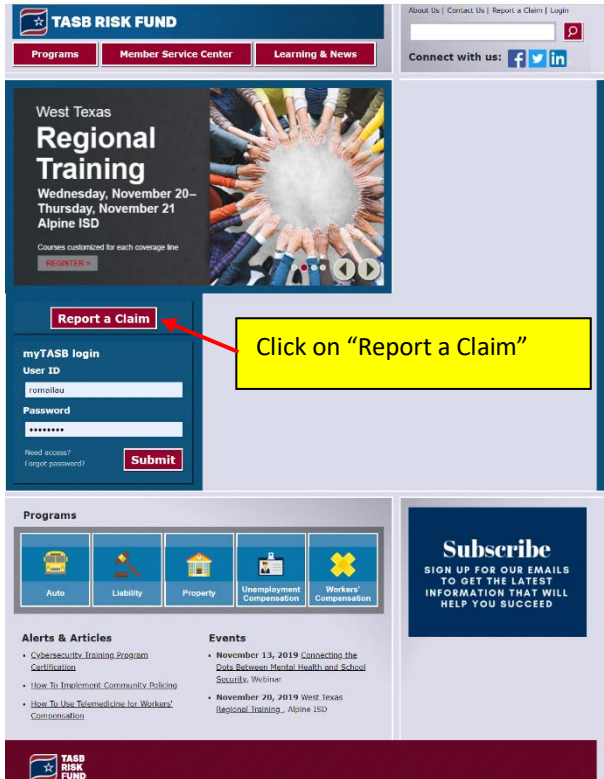
Hourly rate: \$ ____.

Number of hours paid: _____



How to File a First Report of Injury

Go to [this link](#). If link isn't working go to www.tasbrmf.org:



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West Texas
Regional Training
Wednesday, November 20–
Thursday, November 21
Alpine ISD
Courses customized for each coverage line
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romellau
Password

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Home > Member Service Center > Report a Claim

Report a Claim

Report a Claim

If you need immediate assistance, please call 800.482.7276. Calls are answered 24/7, including after hours and on the weekends. If you call outside of business hours, our answering service will contact an adjuster and you will receive a call within one hour.

Workers' Compensation claims

First Report of Injury

- Program administrators who do not use the FROI Administration application, or
- Campuses and departments who need to report an employee injury to their organization's workers' compensation program administrator:

Report a WC claim

If it's your first time filing the First Report of Injury, follow this [step-by-step guide](#).

First Report of Injury Administration

Workers' compensation program administrators, use this to review and submit claims. Claims that have already been submitted to the Fund are not available for review.

FROI Administration

To request access to the FROI Administration application, contact Laura Romaine, workers' compensation program consultant by calling 800.482.7276 x2845 or emailing laura.romaine@tasb.org.

Auto, liability, property, and cyber claims

Report a claim

Watch a short video tutorial that walks you through the process using a hypothetical claim.

myTASB Access

TASB You must have a myTASB user ID and password to access some resources. If you need access, speak with your program contact—the person in your organization responsible for granting user rights. For more information, visit our [myTASB Access page](#).

You are now at the Online First Report of Injury. You may want to bookmark this page so you can go directly to it in the future:



**TASB RISK
MANAGEMENT FUND**

The new tasbrmf.org: Simply better

See it now!

[TASB Risk Management Fund Homepage](#)

Workers' Compensation

First Report of Injury or Illness

Please select your district from the list below then click the submit button.

Member Name



Select your district from the drop down menu and hit submit.

Submit

For additional information or questions, please [e-mail us](#).

P.O. Box 2010, Austin, Texas 78767-2010 • 512-467-0222

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Workers' Compensation

First Report of Injury or Illness

Don't file an amended or corrected copy. If you've submitted and need to make a change, contact Human Resources.

Asterisks denote required information for this report to be properly processed.

Click here if this is a corrected copy: ☐

Please complete the form and note what items have changed in the other information field at the bottom of the form.

EMPLOYER GENERAL INFORMATION

Employer Name
Street Address Line 1:
Street Address Line 2:
City, State, Zip:
Mailing Address Line 1:
Mailing Address Line 2:
City, State, Zip:

Education ISD
123 First Drive
Your City, TX 00000
PO Box ABC
Your City, TX 00000

Tax ID Number:
Phone Number:
SIC Code:

74-xxxxxxx
(555) 555-1212

Insured Report Number:

Some members use this for Employee numbers. You may leave this blank

Campus Code*:

Department Code:
(if applicable)

Select employee's location or campus code from drop down menu.

If there is a Department code choose from the drop down list.

EMPLOYEE INFORMATION

Employee Name (Last, First, MI)*:

Street Address*: 1

Street Address:

City, State, ZIP*: Your Town TX 11111

Phone*: 111 - 111 - 1111

Date of Birth (example: xx/xx/xxxx)*: 01/01/2010

Social Security Number*: 111111111

Date Hired (example: xx/xx/xxxx)*: 01/01/2010

State of Hire*: TX

Sex*: ☐ Male ☐ Female ☒ Unknown

Marital Status*: ☐ Unmarried ☐ Married ☐ Separated ☒ Unknown

Occupation/Job Title*:

Employment Status*: Regular Employee

of Dependents:

Please make every effort to get employee's current mailing address. If unknown, please use address in this example.

If unable to get current phone number, please use 111-111-1111.

If unknown, please use 01/01/2010

If unknown, please use 111-11-1111

Occupation Codes:
 010 - Professional/Clerical/Administration
 020 - Building Maintenance
 030 - Food Service
 040 - Custodial
 050 - Driver & Vehicle Maintenance
 060 - All Other
 Example – 030/Cafeteria Cashier

Select either Regular or Part Time

WAGE INFORMATION

Rate - 0.00 :

Per*: ☐ Week ☐ Bi-Weekly ☐ Semi-Monthly ☐ Month ☐ Hour ☐ Daily

Days Worked/Week*:

Full Pay for Day of Injury? ☐ Yes ☒ No

Gross Amount of Last Paycheck - 0.00: 0

Did Salary Continue? ☐ Yes ☒ No

Type of Pay: ☒ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Has employee elected to use state, sick or vacation leave in lieu of temporary income benefits? ☐ Yes ☐ No ☒ Unknown

If so, how many leave hours have they elected to use?

Please use 1.00

Leave this blank.

OCCURRENCE INFORMATION

Type of Claim*:

Date of Injury/Illness
(example: xx/xx/xxxx)*:

Time Employee Began Work
(example: 08:15)*:

Time of Occurrence
(example: 08:15)*:

Last Work Date
(example: xx/xx/xxxx):

Date Employer Notified
(example: xx/xx/xxxx):

Date Disability Began
(example: xx/xx/xxxx):

Supervisor Name:

Supervisor Phone Number:

Type of Injury/Illness:

Part of Body Affected:

Cause of Injury:

Did injury/illness exposure occur on employer's
premise?

Department or Location where accident or illness
exposure occurred*:

All equipment, material or chemicals employee
was using when accident or illness exposure
occurred:

Specify activity the employee was engaged in
when the accident or illness exposure occurred*:

Work process the employee was engaged in when
accident or illness exposure occurred:

How injury or illness/abnormal health condition
occurred. Describe the sequence of events and
include any objects or substances that directly
injured the employee or made the employee ill*:

Date Returned to Work
(example: xx/xx/xxxx):

If Fatal, Give Date of Death
(example: xx/xx/xxxx):

Were Safeguards or Safety Equipment Provided?

Were they used?

☐ Record Only ☐ Medical Only
☐ Lost Time

AM ☐ PM

AM ☐ PM

☒ Yes ☐ No

☒ Yes ☐ No

☒ Yes ☐ No

Record Only – No lost time, No treatment expected, No questions

Medical Only – Currently working, no more than 3 days of lost time, no questions

Lost Time – All others

Complete ONLY if employee is not at work.

This is the date the secretary, principal, nurse or supervisor first knew of incident.

First date of work missed due to injury. **(This is never the date of injury.)** Leave blank if there was no lost time.

Consult the code lists below. Select the code most applicable. Cuts are lacerations, bruises are contusions.

Example: Reagan Elementary cafeteria or playground. If it did not occur on employer premises, enter address or location. Be sure to note if it's a different location than above.

List all equipment, materials and/or chemicals employee was using, applying, handling or operating when injury occurred. Enter "NA" if none used.

Activity when accident occurred such as cooking, teaching, walking, etc.

The work process employee was doing such as teaching, cooking, etc. Enter "NA" if employee was not working such as walking in hallway, eating, etc.

How injury occurred or was reported by employee. Be short and to the point. Clarify body part and side of body, ex. "Student bit employee on right hand between thumb and index finger."

Date employee actually returned to work. Leave blank if employee is still not working. (NO FUTURE DATES.)

TREATMENT INFORMATION

Physician/Health Care Provider Name (Last, First, MI):

Physician/Health Care Provider Street Address:

Physician/Health Care Provider City, State, ZIP:

Hospital Name:

Hospital Street Address:

Hospital City, State, ZIP:

- ☒ No Medical Treatment
☐ Minor by Employer
☐ Minor Clinic/Hosp
☐ Emergency Care
☐ Hospitalized > 24 Hrs
☐ Future Major Medical/Lost Time Anticipated

Initial Treatment*:

Enter doctor/hospital information if known. Not a mandatory field. Don't worry about inputting addresses

Mandatory

Please list any witnesses known. Do not input student names.

OTHER INFORMATION

Witness

(Name & Phone #):

Date Administrator Notified
(example: xx/xx/xxxx)*:

Date Prepared
(example: xx/xx/xxxx)*:

Preparer's Name & Title*:

Preparer's Phone Number*:

All Other Information:

Campus e-mail address to receive confirmation:

Administrative e-mail address to receive confirmation:

This is the date the location notifies Risk Management or Administration.

This area is available if more room is needed for accident description or other info.

We suggest you leave Administrative email address blank. The administrator gets the form automatically. You may put your email address only in the campus email address. It is not required.

Submit FROI to Your WC Program Administrator

Clear Form

When complete Submit FROI. If you've forgotten a field it will kick back. If accepted you will see a box asking if you wish to save the FROI in PDF format.



Workers' Compensation

First Report of Injury or Illness

You've successfully submitted a First Report when you see this page. Click on the link to see the report in PDF Format.

The First Report of Injury for Doe John has been sent to the Member WC Claim Administrator.

[Click here to print the First Report of Injury in IA-1 Format.](#)

(Please allow popup windows from your browser. The IA-1 form will appear in a separate window. This process may take a few minutes to run.)

[Download FROI/Excel Format](#)

[Download FROI/Text Format](#)

PO Box 400, Austin, Texas 78767-0400 • 512.467.0222

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WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS									
EMPLOYER (NAME, ADDRESS & PHONE #)		CONTRACT/INTERIM/STAFF/CLERK NUMBER		LOCATION NUMBER		REPORT PURPOSE CODE			
		ARREST/CLERK		ARREST/CLERK NUMBER					
		INSURED REPORT NUMBER							
INDUSTRY CODE		EMPLOYER FIRM		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #		PHONE #	
CARRIER/CLAIMS ADMINISTRATOR									
CARRIER (NAME, ADDRESS, & PHONE #)		POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE #)					
		TO							
		<input type="checkbox"/> SELF INSURANCE							
CARRIER FIRM		POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FIRM					
ADVERT FIRM & CODE NUMBER									
EMPLOYEE/INJURED									
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE	
ADDRESS (LAST 20)		SEX		MARITAL STATUS		OCCUPATION/CLASS TITLE			
		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED		EMPLOYMENT STATUS			
PHONE		# OF DEPENDENTS		FULL-TIME OR PART-TIME		NOC CLASS CODE			
DATE PER		DAY WEEK		MONTH OTHER		DATE WORKED/ON		FULL PAY FOR DAY OF INJURY DID SALARY CONTINUE?	
								<input type="checkbox"/> YES <input type="checkbox"/> NO	
OCCURRENCE/TREATMENT									
INVESTIGATED		DATE OF OCCURRENCE		TYPE OF OCCURRENCE		LAST WORK DATE		DATE OF RETURN	
<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> CREATIVE <input type="checkbox"/> RESTRUCTURED		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
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Nature of Injury		
01 No Physical Injury 02 Amputation 03 Angina Pectoris 04 Burn 07 Concussion 10 Contusion 13 Crushing 16 Dislocation 19 Electric Shock 22 Enucleation 25 Foreign Body 28 Fracture 29 Not Used 30 Freezing 31 Hearing Loss or Impairment 32 Heat Prostration 34 Hernia 36 Infection	37 Inflammation 40 Laceration 41 Myocardial Infraction 42 Poisoning-Not OD or Cumulative 43 Puncture 46 Rupture 47 Severance 49 Sprain 52 Strain 53 Syncope 54 Asphyxiation 55 Vascular Loss 58 Vision Loss 59 All Other 60 Dust Disease NOC 61 Asbestosis 62 Black Lung 63 Byssinosis	64 Silicosis 65 Respiratory Disorders (Fumes) 66 Poisoning-Chemical: Not Metals 67 Metal Poisoning 68 Dermatitis 69 Mental Disorder 71 All Other Occupation Disease 72 Loss of Hearing 73 Contagious Disease 74 Cancer 75 Aids 76 VDT - Related Disease 77 Mental Stress 78 Carpel Tunnel Syndrome 80 All Other Cumulative Injuries 90 Multiple Inj - Physical Only 91 Multiple Inj - Physical Psych
19 Cut/Scrape Miscellaneous 20 Collapsing Materials 25 Fall/Slip From Diff. Level 26 Fall/Slip From Ladder/Scaffold 27 Fall/Slip From Grease/Liquid 28 Fall/Slip: Into Openings	58 Strain/Injury: Reaching 59 Strain/Injury: Using Tool/Mach 60 Strain/Injury: Miscellaneous 61 Strain/Injury: Wield or Throw 65 Strike/Step Moving Parts 66 Strike/Step Obj Lifted/Used	90 Not a Physical Cause of Injury 94 Rubbed/Abraded: Repetitive Motion 95 Rubbed/Abraded: Miscellaneous 97 Strain/Injury: Repetitive Motion 98 Cumulative (All Other) 99 Other

Body Part Injured		
10 Multiple Head Injury 11 Skull 12 Brain 13 Ear(s) 14 Eye(s) 15 Nose 16 Teeth 17 Mouth 18 Soft Tissue: Head 19 Facial Bones 20 Multiple Neck Injury 21 Neck Vertebrae 22 Neck Disc 23 Spinal Cord (Neck) 24 Larynx	32 Elbow 33 Lower Arm 34 Wrist 35 Hand 36 Finger(s) 37 Thumb 38 Shoulder(s) 39 Wrist(s) and Hand(s) 40 Multiple Trunk 41 Upper Back Area (Thoracic) 42 Lower Back (Lumbar/Lumbo-Sacral) 43 Disc: Trunk 44 Chest, Ribs, Sternum, Soft Tissue 45 Sacrum and Coccyx 46 Pelvis	51 Hip 52 Upper Leg 53 Knee 54 Lower Leg 55 Ankle 56 Foot 57 Toe(s) 58 Great Toe 60 Lungs 61 Abdomen Including Groin 62 Buttocks 63 Lumbar and or Sacral Vertebra 64 Artificial Appliance 65 Insufficient Info to Identify 66 No Physical Injury
25 Soft Tissue: Neck 26 Trachea 30 Multiple Upper Extremities 31 Upper Arm, Clav. Scapula	47 Spinal Cord 48 Internal Organs 49 Heart 50 Multiple Lower Extremities	90 Multiple Body Parts 91 Body Systems-Single and Multiple 99 Whole Body Impairment