FIRST REPORT OF INJURY

See Instructions on Reverse Side

Enter Dates in MM/DD/YYYY Format

INJURY INFORMATION

1. Date of Injury	2. Time Employee began work on date of injury _____:_____ ◯ am / ◉ pm	3. Time of Injury _____:_____ ◯ am / ◉ pm
4. Did you / Are you/ Will you receive care for the injury? ◯ Yes ◯ No	5. Extent of Medical Treatment: ☐ None ☐ Minor on-site first aid ☐ Clinic/Urgent Care ☐ Emergency/Hospital ☐ Hospitalization more than 24 hours	6. Name of treating physician _____
7. Did the injury occur on work property? ◯ Yes ◯ No *If Yes, go to question 8. If no, skip to question 9.*	8. Name of the work site where injury occurred. *Complete and skip to question 10.*	9. Name and address of the place of the offsite injury.

PERSONAL INFORMATION

10. Employee Name (last, first, middle initial) _____	11. SPPS Employee ID Number _____ 12. Social Security Number _____	13. Date of Birth 14. Union/Bargaining Group: _____

14. Employee Address _____ 15. City _____	16. State _____	17. Zip Code _____	18. Gender Select	19. Marital Status Select

20. Home/Cell Phone _____	21. Date of Hire (MM/YY) _____ / _____	22. Rate of Pay $	23. Job Title:

INJURY DESCRIPTION/ADDITIONAL INFORMATION

24. Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was. *Examples: "Worker was replacing lightbulb in ceiling and fell from second rung of ladder and landed on concrete floor, twisting left ankle." "Employee was restraining a student and was kicked in the right shin, suffered pain and swelling." "Worker slipped on icy sidewalk and fell to ground, suffered scrape on right hand from the sidewalk." "Worker developed soreness in left wrist over time from daily computer key entry."*

25. What was the injury (include part(s) of the body)? *Examples: "Chemical burn on left hand" "Broken left leg" "Bite with broken skin on right arm" "carpal tunnel in right wrist"*

26. What tools, equipment, machines, objects, substances, or human actions were involved? *Examples: chlorine, hand sprayer, forklift, computer keyboard, struck by human*

27. Will employee lose any work time (1 hour or more) due to the injury/illness? ◯ Yes ◯ No *If yes, answer question 28a. If no, skip to question 30.*	28a. First day of lost time: 28b. First day returned to work after injury/ illness:	29. Estimated Return to Work Date:	30. Will the employee have restrictions upon returning to work? ◯ Yes ◯ No	31. If yes to question 30, how long will employee have restrictions?

32. Date of death: _____

REQUIRED INFORMATION

33. Employer Legal Name: **ISD 625 – SAINT PAUL PUBLIC SCHOOLS**

34. Employer Mailing Address: **360 COLBORNE STREET, 3RD FLOOR – HUMAN RESOURCES SAINT PAUL, MN 55102**

35. Employer FEIN: **41-0901311** 36. Unemployment ID: **7972961** 37. NAICS Code: **611110**

38. Employer's Contact Name and Phone #: **Rebecca Murray: 651-744-6336**

39. INSURER NAME: **SAINT PAUL PUBLIC SCHOOLS [SELF-INSURED FOR WORKERS' COMPENSATION]**

40. CLAIMS ADMINISTRATION (CA) COMPANY NAME: **CANNON COCHRAN MANAGEMENT SERVICES**, **INC**. (**CCMSI**) [**TPA**]

39. CA ADDRESS: **11100 WAYZATA BOULEVARD, STE 535, MINNETONKA, MN 55305** 40. CA FEIN: **371057804**

CA CONTACT: **KATI RAMSTAD** FAX# **217-477-5955** PHONE # **952-847-2388**

41. CLAIM # FOR INJURY:

CA USE ONLY:

Claim type code Type of loss code	Late reason code Death result of injury?	Salary paid in lieu of comp? Full Wages Paid on DOI?	Number of dependents (if death related to injury)	BU Number

Date Form Completed:

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

I**f the claim involves death or serious injury (including injuries that later result in death)**, you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence, at P.O. Box 64221, St. Paul, MN 55164-0221.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

• Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form301.
• Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
• Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
• Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
• Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
• Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
• Item 28: Fill in the date you first became aware of the injury or illness.
• Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
• Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
• Item 34: Check all the boxes that apply AT the time you file this form.
• Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see https://www.irs.gov/Businesses/SmallBusinesses-&-Self-Employed/Lost-or-Misplaced-Your-EIN.
• Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
• Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR
(For first reports of injury filed on or after Jan. 1, 2014)

Pursuant to Minnesota Statutes, section 176.231, and Minnesota Rules, part 5220.2530, insurers and self-insured employers must file with the Department's Workers' Compensation Division an electronic first report of injury, according to the requirements set out in sections 2 to 4 of the Minnesota implementation guide, in all cases where a first report of injury is required to be filed under Minnesota Statutes, chapter 176. The Minnesota implementation guide can be found on the Department's website at www.dli.mn.gov/WC/Edi.asp.

A first report of injury submitted by the insurer or self-insured employer in any other manner or format is not considered filed with the division, except for a written first report of injury on a paper form filed by a self-insured employer within seven days of death or serious injury.

If the claim does not involve lost time beyond the waiting period or potential permanent partial disability (PPD), or has not been requested to be filed by the Department, a first report of injury **does** not need to be filed.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.