



**Indiana Worker's Compensation
First Report of Employee Injury/Illness**

| FOR WORKER'S COMPENSATION BOARD USE ONLY | | |
|------------------------------------------|---------------------------|--------------|
| JURISDICTION | JURISDICTION CLAIM NUMBER | PROCESS DATE |

Please Return Completed Form to: 402 W. Washington St., Room W196
Indianapolis, IN 46204-2753
(317) 232-3808

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

| EMPLOYEE INFORMATION | | | | | | | |
|------------------------|---------------|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------|
| SOCIAL SECURITY NUMBER | DATE OF BIRTH | SEX <input type="radio"/> MALE <input type="radio"/> FEMALE | OCCUPATION / JOB TITLE | | | NCCI CLASS CODE | |
| LAST NAME | FIRST | MIDDLE | MARITAL STATUS <input type="radio"/> UNMARRIED <input type="radio"/> MARRIED <input type="radio"/> SEPARATED <input type="radio"/> UNKNOWN | DATE HIRED | STATE OF HIRE | EMPLOYEE STATUS | |
| ADDRESS (INCL ZIP) | | | # OF DEPENDENTS | WAGE \$ | PER <input type="radio"/> HR <input type="radio"/> DAY <input type="radio"/> WK <input type="radio"/> MO <input type="radio"/> YR <input type="radio"/> OTHER: | PAID DAY OF INJ <input type="checkbox"/> | SALARY CONT'D <input type="checkbox"/> |
| PHONE | | | | | | | |

| EMPLOYER INFORMATION | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------|-----------------------|
| EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP) Rose-Hulman Institute of Technology Attn: Susan Butts - CM 21 5500 Wabash Avenue Terre Haute, IN 47803-3999 | EMPLOYER FEDERAL ID# 35-0868149 | SIC CODE | INSURED REPORT NUMBER |
| | LOCATION # | EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | |
| | PHONE # 812-877-8457 | | |
| | CARRIER/ADMINISTRATOR CLAIM NUMBER | REPORT PURCHASE CODE | |

Actual Location of Accident/Exposure (if not on employer's premises):

| CARRIER/CLAIMS ADMINISTRATOR INFORMATION | | | |
|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------|--|
| CLAIMS ADMINISTRATOR (NAME, ADDRESS, PHONE NO) AIG Holdings P.O.Box 1832 Alpharetta, GA 30023 PHONE 800-428-2422 | CARRIER FEDERAL ID# | CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE | |
| | <input checked="" type="checkbox"/> INSURANCE CARRIER | POLICY/SELF-INSURED NUMBER | |
| | <input type="checkbox"/> THIRD PARTY ADMIN | POLICY PERIOD | |
| AGENT NAME MARSH | CODE NUMBER | | |

| OCCURENCE/TREATMENT INFORMATION | | | | | | | |
|-------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| DATE OF THE INJ/EXP | TIME OF OCCURENCE _M | DATE EMPLOYER NOTIFIED | TYPE OF INJURY/EXPOSURE | | | TYPE CODE | |
| LAST WORK DATE | TIME WORKDAY BEGAN | DATE DISABILITY BEGAN | PART OF BODY | | | PART CODE | |
| RTW DATE | DATE OF DEATH | INJURY/EXPOSURE OCCURRED ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO | CONTACT NAME | | | PHONE NUMBER | |
| DEPARTMENT OR LOCATION WHERE ACCIDENT/EXPOSURE OCCURRED | | | ALL EQUIPMENT, MATERIALS, OR CHEMICALS INVOLVED IN ACCIDENT | | | | |
| SPECIFIC ACTIVITY ENGAGED IN DURING ACCIDENT/EXPOSURE | | | WORK PROCESS EMPLOYEE ENGAGED IN DURING ACCIDENT/EXPOSURE | | | | |
| HOW INJURY/EXPOSURE OCCURED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY RELEVANT OBJECTS OR SUBSTANCES | | | | | | CAUSE OF INJURY CODE | |
| NAME OF THE PHYSICIAN / HEALTH CARE PROVIDER | | | | | | INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR: CLINIC/HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL / LOST TIME ANTICIPATED | |
| WITNESSES (NAME, PHONE #) | | | DATE ADMINISTRATOR NOTIFIED | | | | |
| DATE PREPARED | PREPARER'S NAME | TITLE | PHONE NUMBER | | | | |

An employer's failure to report an occupational injury or illness may result in a \$50 fine

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the shaded areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.
2. Enter all dates in MM/DD/YY format.
3. Please return completed forms to:
4. For answers to questions, please call (317) 232-3808

Definitions:

AGENT NAME & CODE NUMBER: Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and/or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (e.g. Acetylene cutting torch, metal plate, etc.).

AVG WG/WK: Claimant's average weekly wage, calculated by totalling the latest 52 weeks of wages (including overtime, tips, etc.) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME/PHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (i.e. Supervisor, HR Person, Nurse, etc.).

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwise designed by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (e.g. Maintenance, Client's Office, Cafeteria, etc.).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE or UK).

HOW INJURY/ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall.).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION/JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury/illness (e.g. Right forearm, low back, etc.).

REPORT PURPOSE CODE: 00 =Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (Return to Work Date): Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT/EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting).

TYPE OF INJURY/ILLNESS: Briefly describe the nature of the injury or illness (e.g. Contusion, Laceration, Fracture, etc.).

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT/EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down hallway (e.g. Building maintenance).

