

## State of Connecticut Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

FRI

Date filed in Chairman's Office

## **Employer's First Report of Occupational Injury or Illness**

Policy / Self-Insured # Policy Period (MMDDYY)  Employee: Last Name First Name Middle Name Gender Occupation / Job Title  D.O. B. (required)  Address (per. Zp)  Date Of Injury / Illness (MMDDYY)  Town of Injury / Illness  Time Employee Began Work am p.m.  Date Of Occurrence cannot be determined p.m.  Date Employer Notified (MMDDYY)  Date Employer Notified (MMDDYY)  Date Disability Began (MMDDYY)  Date Search (MMDDYY)  Type of Injury / Illness  Were Safeguards or Safety cannot be determined p.m.  Date Engloyer Notified (MMDDYY)  Date Disability Began (MMDDYY)  Date Return(ed) to Work (MMDDYY)  Equipment provided? yes no No Injut	File pursuant to C.G.S. § 31-316	for injuries that result in	<u>1 INCAPACITY FOR ONE DAY OR MORE</u> . Ple		lease TYPE or PF	RINT IN INK.		(for WCC use only)		
Employer's Location Address professor.    PEIN	Employer (Name, Address & Zip)		e #		Carrier / Administrator Claim #		OS	OSHA Log Case # Report Purpose Code		
SIG Code    FEN					Jurisdiction		Jurisdiction	on Claim#		
Policy / Self-Insured # Phone #   Calmin Administrator (Name, Address # 2 by Phone # Phone #   P				Employer's Location Address (if different)		Phone	Phone #			
Policy / Self-Insured # Phone #   Calmin Administrator (Name, Address # 2 by Phone # Phone #   P										
Policy / Self-Insured 8    Check, If Self-Insured Policy Period (MASCOYY) FROM TO FROM TO Conder Date of Injury / Illiness (MASCOYY) Sale of Hire Occupation / Job Tifle    Policy Period (MASCOYY) Sale of Hire Occupation / Job Tifle   Policy Period (MASCOYY) Sale of Hire Occupation / Job Tifle   Policy Period (MASCOYY) Sale of Hire Occupation / Job Tifle   Policy Period (MASCOYY) Sale of Hire Occupation / Job Tifle   Policy Period (MASCOYY) Sale of Hire Occupation / Job Tifle   Policy Period (MASCOYY) Sale of Hire Occupation / Job Tifle   Policy Period (MASCOYY) Sale of Hire Occupation / Job Tifle   Pate of Pay \$	SIC Code	FEIN								
Employee: Last Name   First Name   Middle Name   Gender	Carrier (Name, Address & Zip)	#		Claims Administrator (Name, Address & Zip)		Phone	Phone #			
Employee: Last Name   First Name   Middle Name   Gender										
Employee: Last Name   First Name   Middle Name   Gender										
Employee: Last Name   First Name   Middle Name   Gender										
Employee: Last Name	Policy / Self-Insured #	☐ Check, if		if Self-Insured	nd .					
Dote of Injury / Illness (post Zep)  Date of Injury / Illness cocur    Permale   Premale   Return (ed) to Work (MMADOVY)   Part of Body Affected Code	Employee: Last Name	First Name	A albhiM			_				
Address (rot. 29)  Address (rot. 29)  Rate of Pay \$	Employee. Last Name	Filst Name	ivildale i	vame	Gender	Date Hilled (MM/DD/YY)		State of Hire		
Date of Injury / Illness (MMOD0YY)  Town of Injury / Illness  Time Employee Began Work  a.m. p.m. Did Injury / Illness  Time of Occurrence cannot be determined a.m. p.m. Part of Body Affected  Date Employer Notified (MMCD0YY)  Date Employer Notified (MMCD0YY)  Date Last Worked (MMCD0YY)  Date Return(ed) to Work (MMCD0YY)  Date Return(ed) to Work (MMCD0YY)  If Fatal, Date of Death (MMCD0YY)  If Fatal, Date of Death (MMCD0YY)  Date Return(ed) to Work (MMCD0YY)  Date Return(ed) to Work (MMCD0YY)  If Fatal, Date of Death (MMCD0YY)  Date Return(ed) to Work (MMCD0YY)  Date Administrator Notified (MMCD0YY)  Date Administrator Notified (MMCD0YY)  Date Prepared (MMCD0YY)  Date Prepared (MMCD0YY)  Preparer's Name & Title Phone #		#		Male	Occupation / Job Title					
Date of Injury / Illness (MMCD0YY)  Town of Injury / Illness   Hour   Day   Week   Bi-Weekly   Other    Physician / Health Care Provider (Namo, Address & Zp)  Physician / Health Care Provider (Namo, Address & Zp)  Time Employee Began Work   Did Injury / Illness occur on Employer's Premises?   Yes   No    Time of Occurrence   cannot be determined   a.m.   p.m.   Date Employer Notified (MMCD0YY)   Type of Injury / Illness   Date Employer Notified (MMCD0YY)   Type of Injury / Illness Code   Date Last Worked (MMCD0YY)   Part of Body Affected Code   Date Last Worked (MMCD0YY)   Type of Injury / Illness Code   Date Date Death (MMCD0YY)   Hours   Type of Injury / Illness Code   Date Date of Death (MMCD0YY)   Hours   Type of Injury / Illness Code   Date Date of Death (MMCD0YY)   Hours   Type of Injury / Illness Code   Date Return(ed) to Work (MMCD0YY)   Hours   Type of Injury / Illness Code   Date Return(ed) to Work (MMCD0YY)   Hours   Type of Injury / Illness Code   Date Return(ed) to Work (MMCD0YY)   Hours   Type of Injury / Illness Code   Date Return(ed) to Work (MMCD0YY)   Hours   Type of Injury / Illness Code   Date Return(ed) to Work (MMCD0YY)   Hours   Type of Injury / Illness Code   Date Return(ed) to Work (MMCD0YY)   Hours   Type of Injury / Illness Code   Date Return(ed) to Work (MMCD0YY)   Hours   Type of Injury / Illness Code   Date Return(ed) to Work (MMCD0YY)   Hours   Type of Injury / Illness Code   Date Administrator Notified (MMCD0YY)   Date Prepared (MMCD0YY)   Date Administrator Notified (MMCD0YY)   Prepared's Name & Title   Phone #	Address (incl. Zip)					Rate of Ray &				
Date of Injury / Illness (MMDD077)  Time of Occurrence   an m   p.m   on Employer's Premises?   Yes   No   Time of Occurrence   cannot be determined   p.m   Part of Body Affected   Date Employer Notified (MMDD77)  Date Disability Began (MMDD77)  Date Last Worked (MMDD77)  Date Return(ed) to Work (MMDD77)  Date Return(ed) to Work (MMDD77)  Date Occurred   Describe the sequence of events, including any objector or substances that directly injured the employee or made the employee it:  No Medical Treatment   Emergency Care   Minior — by Employer   Date Prepared (MMDD77)  Date Administrator Notified (MMDD77)  Date Prepared (MMDD77)					Female					
Time Employee Began Work										
Time of Occurrence   cannot be determined   a m.   pm.   Part of Body Affected   Part of Body Affected   Type of Injury / Illness Code   Date Employer Notified (MM/DD/YY)   Part of Body Affected Code   Part of Body Affe	Date of Injury / Illness (MM/DD/YY)		Town of Injury / Illness			Physician / Health Care I	Provider (Name,	Address & Zip)		
Time of Occurrence   cannot be determined   Type of Injury / Illness    Date Employer Notified (MMDD/YY)  Date Disability Began (MMDD/YY)  Date Last Worked (MMDD/YY)  Date Return(ed) to Work (MMDD/YY)  Were Safeguards or Safety   Yes   No Equipment provided?   Yes   No Initial Treatment    If Fatal, Date of Death (MMDD/YY)  All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:  Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:  Contact Name  Type of Injury / Illness Code  Part of Body Affected Code  Initial Treatment  No Medical Treatment   Emergency Care directly injured the employee ill.  Minor — by Clinic / Hospital   Future Major Medical — Lost Time Anticipated  Anticipated  Date Administrator Notified (MMDD/YY)  Date Prepared (MMDD/YY)  Date Prepared (MMDD/YY)  Preparer's Name & Title   Phone #	Time Employee Began Work	П	Did Injury / Illness occur			1				
Date Employer Notified (MM/DD/YY)  Date Disability Began (MM/DD/YY)  Date Last Worked (MM/DD/YY)  Date Return(ed) to Work (MM/DD/YY)  Date Return(ed) to Work (MM/DD/YY)  Date Return(ed) to Work (MM/DD/YY)  How Injury / Illiness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:  All equipment, materials, and/or chemicals employee was engaged in when accident or illness exposure occurred:  Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:  Contact Name  Part of Body Affected  Were Safeguards or Safety  Equipment provided?  Yes No  Initial Treatment  Initial Treatment  No Medical Treatment Emergency Care  Initial Treatment  Minor — by Employer Hospitalized More Than 24 Hours  Anticipated  Anticipated  Date Administrator Notified (MM/DD/YY)  Date Prepared (MM/DD/YY)  Preparer's Name & Title  Phone #			on Employer's Premises?	Yes	☐ No					
Date Employer Notified (MM/DDYY)  Date Disability Began (MM/DDYY)  Date Last Worked (MM/DDYY)  Were Safeguards or Safety Equipment provided?  If Fatal, Date of Death (MM/DDYY)  All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:  Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:  Contact Name  Part of Body Affected Code  Part of Body Affe	Time of Occurrence		Type of Injury / Illness							
Date Employer Notified (MM/DD/YY)  Type of Injury / Illness Code  Part of Body Affected Code  Part of Body Affected Code  Vere Safeguards or Safety Equipment provided?  Possible Last Worked (MM/DD/YY)  Date Return(ed) to Work (MM/DD/YY)  If Fatal, Date of Death (MM/DD/YY)  All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:  Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:  Date Administrator Notified (MM/DD/YY)  Type of Injury / Illness Code  Part of Body Affected Code  Part of Body Affected Code  Vere Safeguards or Safety Equipment provided:  No No Medical Treatment  Minor — by Employer  Minor — by Clinic / Hospital  Anticipated  Date Administrator Notified (MM/DD/YY)  Date Prepared (MM/DD/YY)  Preparer's Name & Title  Phone #		Part of Body Affected			ł					
Date Disability Began (MM/DD/YY)    Part of Body Affected Code	Date Employer Notified (MM/DD/YY)				Hospital (Name, Address & Zip)					
Date Last Worked (MM/DD/YY)    Date Return(ed) to Work (MM/DD/YY)   Equipment provided?   Yes   No   If provided, were they used?   Yes   No   If Fatal, Date of Death (MM/DD/YY)   How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:    All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:   Minor — by Employer   Hospitalized More Than 24 Hours   Minor — by Clinic / Hospital   Future Major Medical — Lost Time Anticipated   Date Administrator Notified (MM/DD/YY)   Date Prepared (MM/DD/YY)   Preparer's Name & Title   Phone #	Date Disability Regan (MM/DD/YY)	Type of Injury / Illness Code								
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Date Return(ed) to Work (MM/DD/YY)    Equipment provided?   Yes   No   No   If provided, were they used?   Yes   No   If Fatal, Date of Death (MM/DD/YY)    How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:    All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:    Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:    Contact Name   Phone #	Date Last Worked (MM/DD/YY)									
If provided, were they used? Yes No  If Fatal, Date of Death (MM/DD/YY)  How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:  All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:  Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:  Contact Name  Initial Treatment	Date Return(ed) to Work (MM/DD/Y)	0		ty Yes	☐ No					
How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:    No Medical Treatment   Emergency Care	, , , , ,				☐ No	Initial Treatment				
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:  Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:  Date Administrator Notified (MM/DD/YY)  Date Prepared (MM/DD/YY)  Preparer's Name & Title  Phone #	If Fatal, Date of Death (MM/DD/YY)		of events, including any objects or substances the		inces that	1 _	tment	☐ Emergency Ca	ire	
Was using when accident or illness exposure occurred:    Minor — by Clinic / Hospital	All equipment, materials, and/or che	emicals employee	directly injured the employ	yee or made the	e employee ill:					
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:  Date Administrator Notified (MM/DD/YY)  Preparer's Name & Title  Phone #  Contact Name				<b>l</b> _ · · ·						
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:  Preparer's Name & Title  Phone #							o / 1.00p.ta.	Anticipated	2001 11110	
Preparer's Name & Title Phone #						Date Administrator Notific	ed (MM/DD/YY)	Date Prepared (A	MM/DD/YY)	
Contact Name	engaged in when accident or illness	s exposure occurred:				Preparer's Name & Title	Div			
						. Toparor a Marine & Title	Phone	9#		
Phone # Cause of Injury Code	Contact Name									
	Phone #		Cause of Injury Code							