



DIA USE ONLY

**EMPLOYER'S FIRST REPORT OF INJURY  
 OR FATALITY**

**THIS FORM MUST BE FILED BY THE EMPLOYER IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.**  
*INSTRUCTIONS AND CODES ON THE REVERSE SIDE – Please Print Legibly or Type – Unreadable forms will be returned.*

<b>EMPLOYEE</b>	1. Employee's Name (Last, First, MI):	2. Home Telephone Number:	3. Social Security Number*:	4. Sex: <input type="checkbox"/> M <input type="checkbox"/> F
	5. Home Address (No., Street, City, State & Zip Code):	5a. Native Language Code: Other:	6. Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S	7. No. of Dependents:
	8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):	10. Average Weekly Wage: <input type="checkbox"/> Estimated <input type="checkbox"/> Actual	
<b>EMPLOYER</b>	11. Employer's Name:		12. Federal Tax I.D. Number:	
	13. Employer's Address (No., Street, City, State & Zip Code):		14. Employer's Telephone Number:	
	15. Industry Code (See Reverse Side):		17. W.C. Policy Number:	
	16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR): <b>Acadia Insurance Company 508-786-6600</b>		19. Business Type: <input type="checkbox"/> Service <input type="checkbox"/> Wholesale <input type="checkbox"/> Mfg. <input type="checkbox"/> Retail <input type="checkbox"/> Other _____	
<b>INJURY INFORMATION</b>	18. Self-Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Self-Insurer Number:		20a. Insurer's Case/Claim File No.:	
	20. DATE OF INJURY (mm/dd/yyyy):		22. Location of Injury if not on Employer's Premises:	
	21. Was Employee Injured on Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	23. FIRST day of Total or partial Incapacity to Earn Wages (mm/dd/yyyy):		
	24. FIFTH day of Total or partial Incapacity to Earn Wages (mm/dd/yyyy):		26. Source of Injury (Chemicals, Machinery, etc.):	
	25. If Employee has Died, Date of Death (mm/dd/yyyy):		27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:	
	28. Person to Whom Injury was Reported (list position):		29. Date Reported (mm/dd/yyyy):	30. Date Reported as work related (mm/dd/yyyy):
	31. Injury Code(s)                      Body Part Code(s) a.                      to body part      a. b.                      to body part      b. c.                      to body part      c.	32. Witness(es) to Injury – Give Full Name(s), if none state as such:		
	33. Has Employee Returned to Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		34. Date of Employee Returned to Work (mm/dd/yyyy):	
35. Employee's Regular Occupation:		36. Has Employee Returned to Regular Occupation: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>PREPARER</b>	37. PREPARER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):		38. PREPARER'S Title:	
	39. PREPARER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):		40. Date Prepared (mm/dd/yyyy):	40a. PREPARER'S e-mail address:

\*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report. Form 101 – Revised 7/2013 – Reproduce as needed.  
**THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.**