Alabama Self-Insured worker's compensation fund

Sponsored by the Business Council of Alabama

# Technical Resource Guide

# 2016-4

# Employer's First Report of Injury Form

**Prepared by:**

**Employer's Claim Management, Inc.**
**P.O. Box 5614, Montgomery, Alabama 36103-5614**
**(334) 277-9395  (800) 392-1551  FAX (334) 270-8771**

## EMPLOYER'S FIRST REPORT OF INJURY FORM

The Employer's First Report of Injury form is an Alabama state required form used by an employer to report work related injuries and illnesses to their workers' compensation provider. This form is available to members of The Alabama Self-Insured Workers Compensation Fund on Employer's Claim Management, Inc. website at www.employersclaim.com. Also, there are instructions to complete the form on the website.

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2
Rev. 4/2006

**STATE OF ALABAMA**

**EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE**

Ombudsman 1-800-528-5166

*Check here for* ***Record Only*** ☐

**CLAIM REFERENCE**

| 1. Insured Report Number 23 | 2. Filing Office Claim Number | 3. OSHA Log Case Number 26 |
|---|---|---|
| | | |

**EMPLOYER**

| | |
|---|---|
| 4. Employer Business Name **ABC Inc.** | ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS |
| 5. Physical Address 1 **123 Main Street** | 10. Mailing Address 1 **P.O. Box 987** |
| 6. Physical Address 2 | 11. Mailing Address 2 |
| 7. City **Ourtown** 8. State **Alabama** 9. Zip **12345** | 12. City **Ourtown** 13. State **Alabama** 14. Zip **12345** |

| 15. Federal ID Number **987654321** | 16. U.C. Account Number **00123567800** | 17. NAICS **56471** |
|---|---|---|

**INSURER / FILING OFFICE**

| | |
|---|---|
| 18. Insurer Name **ALABAMA SELF-INSURED WC FUND** | 21. Filing Office Name **Employer's Claim Management, Inc.** |
| 19. Insurer Federal ID Number **63-0773197** | 22. Mailing Address 1 **P.O. Box 5614** |
| | 23. Mailing Address 2 or Telephone Number (**334)277-9395** |
| 20. Type Insurer Ins Co ☐ Self-Insurer ☐ Group Fund ☒ | 24. City **Montgomery** 25. State **AL** 26. Zip **36103-5614** |
| | 27. Filing Office Federal ID Number **63-1034984** |

**EMPLOYEE / WAGES**

| | |
|---|---|
| 28. First Name **John** | 32. Employee ID Number **234-91-7865** |
| 29. Middle Name **David** | 33. Type Employee ID Number |
| 30. Last Name **Smith** | SSN ☒ Passport Number ☐ Green Card ☐ |
| 31 Last Name Suffix (ie. Jr., Sr., III) **Jr.** | Employment Visa ☐ Assigned by Jurisdiction ☐ |

| | | |
|---|---|---|
| 34. Mailing Address 1 **98 Dogwood Street** | 40. Gender Male ☒ Female ☐ | 41. Date of Birth **12/10/64** |
| 35. Mailing Address 2 | | |
| 36. City **Ourtown** 37. State **Alabama** 38. Zip **12345** 39. Phone **334-234-3456** | | 42.Nbr of Dependents **0** |

| | |
|---|---|
| 43. Marital Status Unmarried (Single or Divorced or Widowed) ☐ Married ☒ Separated ☐ Unknown ☐ | 44. Date Hired |
| 45. Occupation Description **Machine Operator** | 46. Number of Days Worked Per Week **5** |
| 47. Wages $ **400** 48. Hourly ☐ Daily ☐ Weekly ☒ Bi-weekly ☐ Monthly ☐ | 49. Received Full Pay For Day of Injury? Yes ☒ No ☐ 50. Did Salary Continue? Yes ☐ No ☒ |

**INJURY / TREATMENT**

| 51. Date of Injury | 52. Time of Injury | 53. Time Employee Began Work | 54. Date Disability Began | 55. Date of Death |
|---|---|---|---|---|
| 6/1/06 | 10:00 a.m. ☒ p.m. ☐ unk ☐ | 8:00 a.m. ☒ p.m. ☐ | 6/2/06 | |

| | |
|---|---|
| PLACE OF ACCIDENT, INJURY, OR EXPOSURE | 61. Injury Occurred on Employer's Premises? Yes ☒ No ☐ |
| 56. Site Address 123 Main Street | |
| 57. City Ourtown 58. State Alabama 59. Zip 12345 | 62. Date Employer Notified 6/1/06 |
| 60. County Johnson | |

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT, HOW THE INJURY OCCURRED, AND THE SPECIFIC INJURY. ( Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet., injuring right ankle.)

Employee was clearing a jam from his equipment. When the jam was cleared, the equipment started unexpectedly, pulling John's left hand past the cutting blade. This resulted in a severe cut to John's left hand.

**PROVIDE DESCRIPTION CODES** to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
**(FOR COMPLETE LIST OF CODES, GO TO HTTP:// DIR.ALABAMA.GOV/WC**

64. Nature of Injury Code 40 - Laceration 65. Part of Body Code 35 - Hand 66. Cause of Injury Code 10 - Machine

| | | |
|---|---|---|
| 67. Initial Treatment | No Medical Treatment ☐ | 68. Name of Treatment Facility **Med Care Inc.** |
| First Aid By Employer ☐ | Minor Clinic / Hospital ☐ | 69. Address **567 Medical Park Drive** |
| Emergency Room ☐ | Hospitalized > 24 Hours ☐ | 70. City **Ourtown** 71. State **Alabama** 72. Zip **12345** |
| Major medical/Lost time ☒ | Hospitalized Overnight ☐ | |

| 73. Name of Physician or Other Health Care Professional | 74. Has Injured Returned to Work | If so, 75. Date |
|---|---|---|
| Dr. Ronald Evans | Yes ☐ No ☒ | 76. Time a.m. ☐ p.m. ☐ |

**OTHER**

| 77. Date Prepared | 78. Preparer's First Name | 79. Last Name | 80. Title | 81. Preparer's Telephone Number |
|---|---|---|---|---|
| 6/2/06 | Robert | Turner | HR Manager | 334-987-6543 |

The following are Frequently Asked Questions corresponding to the box numbers on the First Report of Injury. Timely claim reporting is critical. Not all boxes have to be completed in order to submit the form. If necessary an adjuster will contact you if additional information is required. However, it is extremely helpful if at least the following information is provided:

1. Number used by the employer to identify claim/injured employee
2. ECMI Claim Number (leave blank)
3. OSHA 300 log Column "A" (if applicable)
16. Employer's 10 digit Unemployment Compensation number as shown on State Quarterly Report
17. North American Industrial Classification System - Formally known as SIC Code
28. Provide full name and last known address
32. Employee ID Number (mandatory – preferably social security number)
34. Provide full name and last known address
54. Date physician took employee off work
63. Provide complete details regarding how the accident occurred including specific body part injured
64. Use list to determine correct code or leave blank
65. Use list to determine correct code or leave blank
66. Use list to determine correct code or leave blank
78. Thorough form completion by experienced staff member

For complete instructions, please review our Claims Reporting Procedures on our website at www.employersclaim.com and click on the "Claims" tab to download the 5 page document of Claims Reporting Procedures.

In addition to the First Report of Injury Form, you can download these documents at the "Claims" tab:

- Instructions First Report of Injury
- Nature, Part & Cause Code Search

You can click on “Forms & Documents” to download:

- Accident Investigation Form
- Employee Wage History
- Mileage Reimbursement Form
- Nature, Part & Cause Code Search
- Sample First Report of Injury
- Workers Compensation Poster

All employees should be instructed to report all work related injuries and illnesses, no matter how minor, to their immediate supervisor as soon as possible. Prompt claims reporting can have a significant impact on a workers compensation claim. This impact can be felt by both the employer and the employee. Injury reporting procedures should be established by top management.

A notice of injury can be received from:

- Obvious injury
- Employee reports an injury or illness
- Notice given to co-worker
- Letter of representation from an attorney
- Claim reported by summons

If any of the above circumstances occur, complete the Employer’s First Report of Injury form and send to Employer’s Claim Management, Inc. Send any related material including summons and complaint, correspondence, internal investigation documents, and witness statements.

It is important to promptly report employee injuries to your workers’ compensation insurance carrier. The company should designate a person responsible for reporting employee injuries (claims contact). The claims contact should complete the Employer’s First Report of Injury form and send it to Employer’s Claim Management, Inc. within 3 days of the injury being reported to management.

In addition to assigning a claims contact person, the company should assign accident investigation responsibilities to a designated employee. Accident investigations should be completed as soon as possible and documented using a designated accident investigation form. Accident investigations should identify the cause of the injury and recommended corrective action. Procedures should be established to help insure recommended corrective actions are followed up and completed.

The injured employee requiring off premises medical treatment should be referred to the company authorized physician. Post-accident drug test should be performed according to your company policy. If the claim results in lost time, your company should use a return to work program (light duty program) to bring the injured employee back to work under the restrictions established by the treating physician.

The Employer's First Report of Injury form should be completed for all work related injuries or illnesses that may have the potential to become a workers compensation claim. If an employee reports an injury but does not want to seek medical treatment, the Employer's First Report of Injury form can be completed and marked (at the top of the form) as "For Record Only." Submit the form to Employer's Claim Management, Inc. and the claim will be filed as closed and it will not be computed toward your loss experience and your experience modification rate (EMR). If later, the injured employee request medical treatment, the employee should be referred to the company authorized physician and Employer's Claim Management, Inc. contacted and updated so the claim can be opened, assigned to an adjuster and properly investigated.

Sometimes companies decide to pay for minor medical only claims themselves. If this is the case, the Employer's First Report of Injury form should be marked as "For Record Only" and forwarded to Employer's Claim Management, Inc. for processing. Claims involving lost time can't be paid or processed in house. If later the minor claim worsens or exceeds expectations, inform Employer's Claim Management, Inc. immediately so the claim can be opened, assigned to an adjuster, investigated and processed.

Any claim that involves severe injuries, such as death, amputation, burns or head trauma should be reported to Employer's Claim Management, Inc. immediately at 1-800-392-1551. Also, remember any fatality must be reported to OSHA within 8 hours. Any claim involving an amputation, hospitalization of an employee or loss of eye must be reported to OSHA within 24 hours.

The Employer's First Report of Injury form can be submitted to Employer's Claim Management, Inc. by:

- Email - firstreport@employersclaim.com
- Fax - 334-240-2981
- Mail - P. O. Box 5614, Montgomery, AL 36103
- CompInfoCenter (Electronic Submission)

A user ID and password is required to access the CompInfoCenter. Contact Employer's Claim Management Inc. or visit our website to request a user id and password.

If you have any questions concerning the Employer's First Report of Injury form, you can contact Employer's Claim Management, Inc. at:

Phone – 334-277-9395

Website – www.employersclaim.com

Email – memberservices@employersclaim.com