

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		2. Filing Office Claim Number		3. OSHA Log Case Number	
EMPLOYER					
4. Employer Business Name			ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1			10. Mailing Address 1		
6. Physical Address 2			11. Mailing Address 2 or Phone Number		
7. City	8. State	9. Zip	12. City	13. State	14. Zip
15. Federal ID Number		16. U.C. Account Number		17. NAICS	
INSURER / FILING OFFICE					
18. Insurer Name AL SELF-INSURED WC FUND			21. Filing Office Name Employer's Claim Mgt., Inc. 21a. Service Co. #		
19. Insurer Federal ID Number 63-0773197			22. Mailing Address 1 P.O. Box 5614		
20. Type Insurer Insurance Co. Ins Co #			23. Mailing Address 2 or Telephone Number (334)277-9395		
Self-Insurer SI #			24. City Montgomery 25. State AL 26. Zip 36103-5614		
Group Fund GF #			27. Filing Office Federal ID Number 63-1034984		
EMPLOYEE / WAGES					
28. First Name			32. Employee ID Number		
29. Middle Name			33. Type Employee ID Number		
30. Last Name			SSN	Passport Number	Green Card
31. Last Name Suffix (ie. Jr., Sr., III)			Employment Visa	Assigned by Jurisdiction	
34. Mailing Address 1			40. Gender		41. Date of Birth
35. Mailing Address 2			Male		42. Nbr of Dependents
36. City			Female		
37. State			39. Phone		
43. Marital Status			44. Date Hired		
Unmarried (Single or Divorced or Widowed)			Married		Separated
45. Occupation Description			46. Number of Days Worked Per Week		
47. Wages \$			49. Received Full Pay For Day of Injury? Yes No		
48. Hourly Daily Weekly Bi-weekly Monthly			50. Did Salary Continue? Yes No		
INJURY / TREATMENT					
51. Date of Injury		52. Time of Injury		53. Time Employee Began Work	
		a.m. p.m. unk		a.m. p.m.	
PLACE OF ACCIDENT, INJURY, OR EXPOSURE				61. Injury Occurred on Employer's Premises?	
56. Site Address				Yes No	
57. City		58. State		59. Zip	
60. County				62. Date Employer Notified	
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)					
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 HTTPS://LABOR.ALABAMA.GOV)					
64. Nature of Injury Code		65. Part of Body Code		66. Cause of Injury Code	
67. Initial Treatment		68. Name of Treatment Facility		69. Address	
No Medical Treatment		First Aid By Employer		70. City	
Minor Clinic / Hospital		Emergency Room		71. State	
Hospitalized > 24 Hours		Major medical/Lost time		72. Zip	
Hospitalized Overnight					
73. Name of Physician or Other Health Care Professional			74. Has Injured Returned to Work		If so, 75. Date
			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	