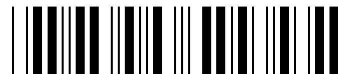
First Report of Injury

See Instructions on Reverse Side
Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.



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DO NOT USE THIS SPACE

Minnesota Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road North
St. Paul, MN 55155-4305
(651) 284-5030

1. **EMPLOYEE SOCIAL SECURITY#**

2. **DATE OF CLAIMED INJURY**

3. **EMPLOYEE** Name (last, first, middle)	4. Time of injury ☐ am ☐ pm	5. Gender ☐ M ☐ F
6. Home address	7. Time employee began work ☐ am ☐ pm	
City State Zip Code	8. Date of birth	
9. Occupation	10. Marital Status ☐ Married ☐ Unmarried	11. Apprentice ☐ Yes ☐ No
12. Regular department	13. Home phone #	14. Date hired

15. Average wage/week	16. Rate per hour	17. Hours per day	18. Days per week
19. Weekly value of:	Meals	Lodging	2nd income

20. Employment Status: ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer (attach 26 week wage statement for part-time or irregularly scheduled employee)

21. Place of occurrence	On employer's premises? ☐ Yes ☐ No	22. Date of first day of any lost time	23. Date employer notified of injury
Address		24. Return to work date	25. Date employer notified of lost time
City State Zip Code		26. Date of death	27. OSHA Case#

28. **Tell us how the injury occurred and what the employee was doing before the incident (give details).** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

29. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*

30. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

31. PHYSICIAN (full name and title)	32. HOSPITAL/CLINIC name	33. Emergency Room ☐ Yes ☐ No
Address	Address	34. Overnight in-patient ☐ Yes ☐ No
Phone #		

35. **EMPLOYER** (Legal name)	36. Date form completed	37. Unemployment ID#	38. NAICS code
Mailing address	39. Witness name and phone number		
City State Zip Code	40. Employer's contact name (print full name, title, and phone #)		

41. Insurer ID#	42. Claim Administrator Claim #	43. Third Party Administrator ID #

44. **INSURER**	45. Date insurer received notice	46. **THIRD PARTY ADMINISTRATOR**
Address		Address
City State Zip Code		City State Zip Code

IMPORTANT NOTICE

The filing of this report is not an admission of liability. It should be filed with your insurance carrier whenever anyone believes a work-related injury or illness has occurred. The prompt filing of this report with your insurance carrier and the Department of Labor and Industry is required by law. Failure to report the claim within ten days may subject you to penalties. (If you are self-insured, your time limit is 14 days.) You should file this report immediately with your insurer. This will allow your insurer as much time as possible to investigate the claim. Even if the claim is questionable, it is important that you report it promptly. If you question the claim, attach any additional information to this report. Each case should also be recorded on your OSHA 300 log, if necessary. This form contains all items required by OSHA form 301.

GENERAL INSTRUCTIONS TO THE EMPLOYER

Death or serious injury arising from employment must be reported to the Department of Labor and Industry within 48 hours of the occurrence. You may initially report by telephone (651-284-5041), facsimile (651-215-0170), or personal notice within 48 hours, but that notice must be followed by the filing of this report with your insurer within seven days of the occurence. If a reported injury subsequently results in death, a report of the death must be made to the Department and your insurer within 48 hours of when you are notified of the death.

Whenever you become aware of any work-related injury or illness that requires medical care or lost time from work, you must report the injury to your insurer as soon as possible. If the employee cannot work for a period of more than three days, the workers' compensation claim must be made on this form and reported to your insurer within ten days. However, your insurer may require that you file it sooner. Your insurer will forward the form to the Department of Labor and Industry, if necessary.

Please print or type. It is absolutely essential that you fill in all the information you can. Each piece of information is needed to determine liability and entitlement to benefits. Failure to complete the form may result in delayed processing and possible penalties. Provide copies to your insurance carrier and your injured worker. If the claim results in the employee's inability to work for a period of more than three days, send a copy of this report to the employee's local union office. Fill in all the information you can, except items 41-46.

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON FILLING OUT THE FIRST REPORT OF INJURY FORM

- Item 15-19: Fill in all the wage information. If the claimant does not work a regular work week, attach a **26 week wage statement** and your insurer will calculate the appropriate average weekly wage.
- Item 22: Fill in the first day the employee lost any time from work, even if you paid the employee for the full day.
- Item 23: Fill in the date you first became aware of the injury or illness. This is used to determine whether the form is filed on time. You have ten days from the date you became aware of this injury to report this to your carrier.
- Item 24: If the employee has not returned to work by the time you are filing this form, leave the box blank. If the employee has returned to work and you indicate this on the form, be sure to notify your insurer immediately if the injured employee misses time later due to this injury.
- Item 25: Fill in the date you became aware that the time loss indicated in Item 22 was related to the claimed injury.
- Item 27: OSHA Case #. Fill in the case number from the OSHA 300 log.
- Item 28: Be as specific as possible in describing the events causing the injury.
- Item 29: Be as specific as possible in describing the nature of the injury (cut, sprain, burn, etc.), and indicate the part(s) of body injured (back, arm, etc.).
- Item 30: Be as specific as possible in describing the tools, equipment, machines, objects, or substances involved.
- Item 37 and 38: Fill in the Unemployment ID number and North American Industry Classification System (NAICS). These numbers are assigned by the Department of Economic Security. Call them at 651-296-6141 if you do not have a NAICS code or Unemployment ID number.
- Do not fill in items 41-46. Your insurer will add this information.

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR DOCTOR'S REPORT

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.