Indiana Worker's Compensation
First Report of Employee Injury/Illness

Please Return Completed Form to: 402 W. Washington St., Room W196
Indianapolis, IN 46204-2753
(317) 232-3808

FOR WORKER'S COMPENSATION BOARD USE ONLY		
JURISDICTION	JURISDICTION CLAIM NUMBER	PROCESS DATE

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX ◯MALE ◯FEMALE ◯UNKNOWN	OCCUPATION/JOB TITLE	NCCI CLASS CODE
LAST NAME	FIRST	MIDDLE	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		MARITAL STATUS ◯UNMARRIED ◯MARRIED ◯SEPARATED ◯UNKNOWN	EMPLOYEE STATUS	
			HRS/DAY / DAYS/WK / AVG WG/WK	PAID DAY OF INJ ☐ SALARY CONT'D ☐
PHONE		# OF DEPENDENTS	WAGE $	PER ◯HR ◯DAY ◯WK ◯MO ◯YR ◯OTHER:

EMPLOYER INFORMATION

EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP)	EMPLOYER FEDERAL ID#	SIC CODE	INSURED REPORT NUMBER
	LOCATION #	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
	PHONE #		
	CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
Actual Location of Accident/Exposure (if not on employer's premises):			

CARRIER/CLAIMS ADMINISTRATOR INFORMATION

CLAIMS ADMINISTRATOR (NAME, ADDRESS, PHONE NO)	CARRIER FEDERAL ID#	CHECK IF APPROPRIATE ☐ SELF INSURANCE
	☐ INSURANCE CARRIER	POLICY/SELF-INSURED NUMBER
PHONE:	☐ THIRD PARTY ADMIN	POLICY PERIOD FROM TO
AGENT NAME	CODE NUMBER	

OCCURRENCE/TREATMENT INFORMATION

DATE OF INJ/EXP	TIME OF OCCURRENCE ___M	DATE EMPLOYER NOTIFIED	TYPE OF INJURY/EXPOSURE	TYPE CODE
LAST WORK DATE	TIME WORKDAY BEGAN	DATE DISABILITY BEGAN	PART OF BODY	PART CODE
RTW DATE	DATE OF DEATH	INJURY/EXPOSURE OCCURRED ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	CONTACT NAME	PHONE NUMBER
DEPARTMENT OR LOCATION WHERE ACCIDENT/EXPOSURE OCCURRED			ALL EQUIPMENT, MATERIALS, OR CHEMICALS INVOLVED IN ACCIDENT	
SPECIFIC ACTIVITY ENGAGED IN DURING ACCIDENT/EXPOSURE			WORK PROCESS EMPLOYEE ENGAGED IN DURING ACCIDENT/EXPOSURE	
HOW INJURY/EXPOSURE OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY RELEVANT OBJECTS OR SUBSTANCES				CAUSE OF INJURY CODE
NAME OF PHYSICIAN/HEALTH CARE PROVIDER				INITIAL TREATMENT ☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR: CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED >24 HRS ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED
WITNESSES (NAME, PHONE #)			DATE ADMINISTRATOR NOTIFIED	
DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER	

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13)

STATE FORM 34401 (R8 2/96)

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the shaded areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.
2. Enter all dates in MM/DD/YY format.
3. Please return completed forms to: **Indiana Worker's Compensation Board**
402 W. Washington St., Room W196
Indianapolis, IN 46204-2753
4. For answers to questions, please call **(317) 232-3808**.

Definitions:

AGENT NAME & CODE NUMBER: Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and/or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (e.g. Acetylene cutting torch, metal plate, etc.).

AVG WG/WK: Claimant's average weekly wage, calculated by totalling the latest 52 weeks of wages (including overtime, tips, etc.) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME/PHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (i.e. Supervisor, HR Person, Nurse, etc.)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised deigned by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (e.g. Maintenance, Client's Office, Cafeteria, etc.).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-Time, Apprentice Full-Time, Apprentice Part Time, Volunteer, Seasonal Worker, Piece Worker, On-Strike. Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE or UK).

HOW INJURY/ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION/JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury/illness (e.g. Right forearm, Low Back, etc.).

REPORT PURPOSE CODE: 00 = Original First Report of Injury; **02**=Updated or Amended First Report.

RTW DATE (Return to Work Date): Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT/EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting).

TYPE OF INJURY/ILLNESS: Briefly describe the nature of the injury or illness (e.g. Contusion, Laceration, Fracture, etc.)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT/EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (e.g. Building maintenance).