



**State of Connecticut
Workers' Compensation Commission**

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Date filed in Chairman's Office

(for WCC use only)

Employer (Name, Address & Zip)		Phone #	Carrier / Administrator Claim #	OSHA Log Case #	Report Purpose Code
SIC Code		FEIN	Jurisdiction	Jurisdiction Claim #	
			Employer's Location Address (if different)	Phone #	
Carrier (Name, Address & Zip)		Phone #	Claims Administrator (Name, Address & Zip)		Phone #
Policy / Self-Insured #		<input type="checkbox"/> Check, if Self-Insured	Policy Period (MM/DD/YY) FROM: TO:		
Employee: Last Name		First Name	Middle Name	Gender	Date Hired (MM/DD/YY)
D.O.B. (required)		Phone #		<input type="checkbox"/> Male	State of Hire
Address (incl. Zip)				<input type="checkbox"/> Female	Occupation / Job Title
				Rate of Pay \$ _____ per	NCCI Class Code
				<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other	
Date of Injury / Illness (MM/DD/YY)	Town of Injury / Illness		Physician / Health Care Provider (Name, Address & Zip)		
Time Employee Began Work	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Did Injury / Illness occur on Employer's Premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Time of Occurrence	<input type="checkbox"/> cannot be determined <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Type of Injury / Illness			
Date Employer Notified (MM/DD/YY)	Part of Body Affected				
Date Disability Began (MM/DD/YY)	Type of Injury / Illness Code		Hospital (Name, Address & Zip)		
Date Last Worked (MM/DD/YY)	Part of Body Affected Code				
Date Return(ed) to Work (MM/DD/YY)	Were Safeguards or Safety Equipment provided?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Initial Treatment	
	If provided, were they used?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Care	
If Fatal, Date of Death (MM/DD/YY)	How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill.		<input type="checkbox"/> Minor — by Employer <input type="checkbox"/> Hospitalized More Than 24 Hours		
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:			<input type="checkbox"/> Minor — by Clinic / Hospital <input type="checkbox"/> Future Major Medical — Lost Time Anticipated		
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:			Date Administrator Notified (MM/DD/YY)	Date Prepared (MM/DD/YY)	
Contact Name			Preparer's Name & Title	Phone #	
Phone #			Cause of Injury Code		