



**State of Connecticut  
Workers' Compensation Commission**

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

Rev. 3-17-2006

**FRI**

Date filed in Chairman's Office

**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.

*(for WCC use only)*

Employer (Name, Address & Zip)		Phone #	Carrier / Administrator Claim #	OSHA Log Case #	Report Purpose Code
SIC Code		FEIN	Jurisdiction	Jurisdiction Claim #	
Carrier (Name, Address & Zip)		Phone #	Employer's Location Address (if different)		Phone #
Carrier (Name, Address & Zip)		Phone #	Claims Administrator (Name, Address & Zip)		
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)	State of Hire
Address (incl. Zip)		Phone #	<input type="checkbox"/> Male	Occupation / Job Title	
Date of Birth (MM/DD/YY)		Social Security #	<input type="checkbox"/> Female	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		Hospital (Name, Address & Zip)		
Date Disability Began (MM/DD/YY)	Type of Injury / Illness Code				
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		
If Fatal, Date of Death (MM/DD/YY)	If provided, were they used?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:	How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:		Initial Treatment		
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:			<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Care		
Contact Name			<input type="checkbox"/> Minor — by Employer <input type="checkbox"/> Hospitalized More Than 24 Hours		
Phone #			<input type="checkbox"/> Minor — by Clinic / Hospital <input type="checkbox"/> Future Major Medical — Lost Time Anticipated		
	Cause of Injury Code		Date Administrator Notified (MM/DD/YY)	Date Prepared (MM/DD/YY)	
			Preparer's Name & Title	Phone #	