

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE
Ombudsman 1-800-528-5166

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 Telephone 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		21. Filing Office Name		21a. Service Co. #	
19. Insurer Federal ID Number		22. Mailing Address 1			
20. Type Insurer <input type="checkbox"/> Insurance Co. Ins Co #		23. Mailing Address 2 or Telephone Number			
<input type="checkbox"/> Self-Insurer SI #		24. City		25. State	26. Zip
<input type="checkbox"/> Group Fund GF #		27. Filing Office Federal ID Number			
EMPLOYEE / WAGES					
28. First Name			32. Employee ID Number		
29. Middle Name			33. Type Employee ID Number		
30. Last Name			SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)			Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1			40. Gender		41. Date of Birth
35. Mailing Address 2			Male <input type="checkbox"/>		42. Nbr of Dependents
36. City			Female <input type="checkbox"/>		
37. State			38. Zip		39. Phone
43. Marital Status					44. Date Hired
Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>					
45. Occupation Description				46. Number of Days Worked Per Week	
47. Wages \$		49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>			
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>		50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>			
INJURY / TREATMENT					
51. Date of Injury	52. Time of Injury		53. Time Employee Began Work		54. Date Disability Began
	a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		55. Date of Death
PLACE OF ACCIDENT, INJURY, OR EXPOSURE			61. Injury Occurred on Employer's Premises?		
56. Site Address			Yes <input type="checkbox"/> No <input type="checkbox"/>		
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 HTTP:// DIR.ALABAMA.GOV/WC)					
64. Nature of Injury Code		65. Part of Body Code		66. Cause of Injury Code	
67. Initial Treatment			68. Name of Treatment Facility		
No Medical Treatment <input type="checkbox"/> First Aid By Employer <input type="checkbox"/>			69. Address		
Minor Clinic / Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/>			70. City		
Hospitalized > 24 Hours <input type="checkbox"/> Major medical/Lost time <input type="checkbox"/>			71. State		72. Zip
Hospitalized Overnight <input type="checkbox"/>			73. Name of Physician or Other Health Care Professional		
			74. Has Injured Returned to Work		If so, 75. Date
			Yes <input type="checkbox"/> No <input type="checkbox"/>		76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
OTHER					
77. Date Prepared	78. Preparer's First Name		79. Last Name		80. Title
					81. Preparer's Telephone Number