

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. <input type="checkbox"/> Self-Insurer <input type="checkbox"/> Group Fund		Ins Co #		23. Mailing Address 2 or Telephone Number	
		SI #		24. City	
		GF #		25. State	
				26. Zip	
		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"/>		44. Date Hired
37. State			38. Zip		39. Phone
43. Marital Status 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 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>		53. Time Employee Began Work a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	54. Date Disability Began
55. Date of Death					
PLACE OF ACCIDENT, INJURY, OR EXPOSURE				61. Injury Occurred on Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>	
56. Site Address				62. Date Employer Notified	
57. City				58. State	
59. Zip				60. County	
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 No Medical Treatment <input type="checkbox"/> First Aid By Employer <input type="checkbox"/> Minor Clinic / Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/> Major medical/Lost time <input type="checkbox"/> Hospitalized Overnight <input type="checkbox"/>			68. Name of Treatment Facility		
			69. Address		
			70. City		
			71. State		
			72. Zip		
73. Name of Physician or Other Health Care Professional			74. Has Injured Returned to Work Yes <input type="checkbox"/> No <input type="checkbox"/>		If so, 75. Date
					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	