THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKERS'S COMPENSATION LAW

WCC Form 2
Rev. 9/2006

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 5. Physical Address 1 6. Physical Address 2 7. City 8. State 9. Zip	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS 10. Mailing Address 1 11. Mailing Address 2 or Telephone Number 12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number	17. NAICS

INSURER / FILING OFFICE

18. Insurer Name CARECOMP 19. Insurer Federal ID Number 63-1080684 20. Type Insurer ☐ Insurance Co. Ins Co # ☐ Self-Insurer SI # ☒ Group Fund GF #	21. Filing Office Name Millennium Risk Managers, LLC 21a. Service Co. # 22. Mailing Address 1 P O Box 382408 23. Mailing Address 2 or Telephone Number (205) 451-0812 24. City Birmingham 25. State AL 26. Zip 35238 27. Filing Office Federal ID Number 63-1220442

EMPLOYEE / WAGES

28. First Name 29. Middle Name 30. Last Name 31 Last Name Suffix (ie. Jr., Sr., III)	32. Employee ID Number 33. Type Employee ID Number SSN ☒ Passport Number ☒ Green Card ☐ Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1 35. Mailing Address 2 36. City 37. State 38. Zip 39. Phone	40. Gender Male ☐ Female ☐	41. Date of Birth 42.Nbr of Dependents
43. Marital Status Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐		44. Date Hired
45. Occupation Description		46. Number of Days Worked Per Week
47. Wages $ 48. Hourly ☐ Daily ☒ Weekly ☐ Bi-weekly ☐ Monthly ☐	49. Received Full Pay For Day of Injury? Yes ☐ No ☒ 50. Did Salary Continue? Yes ☒ No ☐	

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE 56. Site Address 57. City 58. State 59. Zip 60. County	61. Injury Occurred on Employer's Premises? Yes ☒ No ☐ 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 No Medical Treatment ☐ First Aid By Employer ☐ Minor Clinic / Hospital ☐ Emergency Room ☐ Hospitalized > 24 Hours ☐ Major medical/Lost time ☐ Hospitalized Overnight ☐	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 ☐ No ☒	If so, 75. Date 76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name 79. Last Name 80. Title	81. Preparer's Telephone Number