



# INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R9 / 3-01)

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

Please return completed form electronically by an approved EDI process.

**PLEASE TYPE or PRINT IN INK**

*NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.*

EMPLOYEE INFORMATION						
Social Security number	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Occupation / Job title		NCCI class code	
Name (last, first, middle)		Marital status <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	Date hired	State of hire	Employee status	
Address (number and street, city, state, ZIP code)			Hrs / Day	Days / Wk	Avg Wg / Wk	<input type="checkbox"/> Paid Day of Injury <input type="checkbox"/> Salary Continued
Telephone number (include area code)		Number of dependents	Wage Per \$ <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year <input type="checkbox"/> Other			

EMPLOYER INFORMATION			
Name of employer	Employer ID#	SIC code	Insured report number
Address of employer (number and street, city, state, ZIP code)	Location number	Employer's location address (if different)	
	Telephone number		
Carrier / Administrator claim number			Report purpose code
Actual location of accident / exposure (if not on employer's premises)			

CARRIER / CLAIMS ADMINISTRATOR INFORMATION			
Name of claims administrator	Carrier federal ID number	Check if appropriate <input type="checkbox"/> Self Insurance	
Address of claims administrator (number and street, city, state, ZIP code)	<input type="checkbox"/> Insurance Carrier <input type="checkbox"/> Third Party Admin.	Policy / Self-insured number	
		Policy period From _____ To _____	
Telephone number	Code number		
Name of agent			

OCCURRENCE / TREATMENT INFORMATION						
Date of Inj./ Exp.	Time of occurrence <input type="checkbox"/> AM <input type="checkbox"/> PM	Date employer notified	Type of injury / exposure		Type code	
Last work date	Time workday began	Date disability began	Part of body		Part code	
RTW date	Date of death	Injury / Exposure occurred on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of contact		Telephone number	
Department or location where accident / exposure occurred			All equipment, materials, or chemicals involved in accident			
Specific activity engaged in during accident / exposure			Work process employee engaged in during accident / exposure			
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.						Cause of injury code
Name of physician / health care provider					<b>INITIAL TREATMENT</b> <input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinic / Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/> Future Major Medical / Lost Time Anticipated	
Name of witness		Telephone number	Date administrator notified			
Date prepared	Name of preparer	Title	Telephone number			

An employer's failure to report an occupational injury or illness may result in a \$50 fine (IC 22-3-4-13).