Minnesota Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road North
St. Paul, MN 55155-4305
(651) 284-5030

First Report of Injury

See Instructions on Reverse Side
PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY # | 2. OSHA Case #

3. DATE OF CLAIMED INJURY | 4. Time of injury ☐ am ☐ pm | 5. Time employee began work on date of injury ☐ am ☐ pm

6. EMPLOYEE Name (last, first, middle) | 7. Gender ☐ M ☐ F | 8. Marital Status ☐ Married ☐ Unmarried

9. Home Address | 10. Home phone # | 11. Date of birth

City | State | Zip Code | 12. Occupation | 13. Regular department | 14. Date hired

15. Average weekly wage | 16. Rate per hour | 17. Hours per day | 18. Days per week | 19. Employment Status ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

20. Weekly value of: | Meals | Lodging | 2nd Income | 21. Apprentice ☐ Yes ☐ No

22. **Tell us how the injury occurred and what the employee was doing before the incident (give details).** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*

24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No
If no, indicate name and address of place of occurrence

26. Date of first day of any lost time

27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI

28. Date employer notified of injury

29. Date employer notified of lost time

30. Return to work date

31. Date of death

32. TREATING PHYSICIAN (name, address, and phone) | 33. HOSPITAL/CLINIC (name and address) (if any) | 34. Emergency Room Visit ☐ Yes ☐ No | 35. Overnight in-patient ☐ Yes ☐ No

36. **EMPLOYER** Legal name | 37. EMPLOYER DBA name (if different)

38. **Mailing** address | 39. Employer FEIN | 40. Unemployment ID#

City | State | Zip Code | 41. Employer's contact name and phone #

42. **Physical** address (if different) | 43. Witness (name and phone)

City | State | Zip Code | 44. NAICS code | 45. Date form completed

46. **INSURER** name | 51. **CLAIMS ADMIN COMPANY** (CA) name (check one) ☐ Insurer ☐ TPA

47. Insured legal name | 52. CA address

48. Policy # or self-insured certificate # | City | State | Zip Code

49. Insurer FEIN | 50. Date insurer received notice | 53. CA FEIN | 54. Claim #

Copies to: Insurer, Employer, Employee, and Workers' Compensation Division (if no insurer)