

STATE OF ALABAMA  
EMPLOYER'S FIRST REPORT OF INJURY  
OR OCCUPATIONAL DISEASE

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		
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		
19. Insurer Federal ID Number		22. Mailing Address 1		
20. Type Insurer		23. Mailing Address 2 or Telephone Number		
Ins Co <input type="checkbox"/> Self-Insurer <input type="checkbox"/> Group Fund <input type="checkbox"/>		24. City 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"/>		
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	55. Date of Death
	a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>	a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		
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			62. Date Employer Notified	
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.)				
<b>PROVIDE DESCRIPTION CODES to identify Nature of Injury, Part of Body that was affected, and Cause of Injury.</b> <b>(FOR COMPLETE LIST OF CODES, GO TO <a href="http://LABOR.ALABAMA.GOV/WC">HTTP:// LABOR.ALABAMA.GOV/WC</a>)</b>				
64. Nature of Injury Code		65. Part of Body Code		66. Cause of Injury Code
67. Initial Treatment		No Medical Treatment <input type="checkbox"/>		68. Name of Treatment Facility
First Aid By Employer <input type="checkbox"/>		Minor Clinic / Hospital <input type="checkbox"/>		
Emergency Room <input type="checkbox"/>		Hospitalized Overnight <input type="checkbox"/>		
Hospitalized > 24 Hours <input type="checkbox"/>		Outpatient Treatment <input type="checkbox"/>		
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