

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 25. State 26. Zip	
		GF #		24. 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 37. State 38. Zip 39. Phone			Female <input type="checkbox"/>		
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/Department			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 58. State 59. Zip 60. County			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			68. Name of Treatment Facility		
No Medical Treatment <input type="checkbox"/> First Aid By Employer <input type="checkbox"/>			69. Address		
Minor Clinic / Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/>			70. City 71. State 72. Zip		
Hospitalized > 24 Hours <input type="checkbox"/> Major medical/Lost time <input type="checkbox"/>					
Hospitalized Overnight <input type="checkbox"/>					
73. Name of Physician or Other Health Care Professional			74. Has Injured Returned to Work		If so, 75. Date
			Yes <input type="checkbox"/> No <input type="checkbox"/>		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