



**State of Connecticut
Workers' Compensation Commission**

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 3-17-2006

FRI

Date filed in Chairman's Office

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

(for WCC use only)

Employer (Name, Address & Zip)		Phone #	Carrier / Administrator Claim #		OSHA Log Case #	Report Purpose Code
SIC Code		FEIN	Jurisdiction	Jurisdiction Claim #		
Carrier (Name, Address & Zip)		Phone #	Claims Administrator (Name, Address & Zip)		Phone #	
Date of Injury / Illness (MM/DD/YY)		Town of Injury / Illness	Physician / Health Care Provider (Name, Address & Zip)			
Time Employee Began Work		<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Did Injury / Illness occur on Employer's Premises?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Time of Occurrence		<input type="checkbox"/> cannot be determined <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Type of Injury / Illness			
Date Employer Notified (MM/DD/YY)		Part of Body Affected		Hospital (Name, Address & Zip)		
Date Disability Began (MM/DD/YY)		Type of Injury / Illness Code		Initial Treatment		
Date Last Worked (MM/DD/YY)		Part of Body Affected Code		<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Care		
Date Return(ed) to Work (MM/DD/YY)		Were Safeguards or Safety Equipment provided?		<input type="checkbox"/> Minor — by Employer <input type="checkbox"/> Hospitalized More Than 24 Hours		
If Fatal, Date of Death (MM/DD/YY)		If provided, were they used?		<input type="checkbox"/> Minor — by Clinic / Hospital <input type="checkbox"/> Future Major Medical — Lost Time Anticipated		
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:		How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:				
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:		Date Administrator Notified (MM/DD/YY)				
Contact Name		Date Prepared (MM/DD/YY)				
Phone #		Preparer's Name & Title				
Cause of Injury Code		Phone #				