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Department of Labor
 Office of Workers' Compensation
 P.O. Box 9954
 Wilmington, DE 19809-9954
 Telephone 302-761-8200

**STATE OF DELAWARE
 FIRST REPORT
 OF
 OCCUPATIONAL INJURY
 OR DISEASE**

CASE OR FILE NO. _____

EMPLOYER'S UC REPORTING NUMBER _____

EMPLOYEE	1.. EMPLOYEE: FIRST MIDDLE LAST			2. EMPLOYEE SOCIAL SECURITY NO. - -		
	3. ADDRESS - INCLUDE COUNTY AND ZIP CODE			4. MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	5. EMPLOYEE TELEPHONE NUMBER (INCLUDE AREA CODE) - -	
	6. . DATE OF BIRTH - -	7. AGE	8. WAGE	9. WEEKLY HOURS WORKED		
	10. OCCUPATION (REGULAR)		11. DEPARTMENT OF DIVISION REGULARLY EMPLOYED		12. HOW LONG EMPLOYED	
EMPLOYER	13.. EMPLOYER			14. PERSON MAKING OUT THIS REPORT		
	15. ADDRESS - INCLUDE COUNTY AND ZIP CODE			16. EMPLOYER TELEPHONE NUMBER (INCLUDE AREA CODE) - -		
	17. MAILING ADDRESS - IF DIFFERENT THAN ABOVE		18. NATURE OF BUSINESS - TYPE OF MFG., TRADE, CONSTRUCTION, SERVICE, ETC.			
DATES	19. DATE OF REPORT - -	20. DATE OF INJURY AND TIME - - <input type="checkbox"/> AM <input type="checkbox"/> PM	21. NORMAL STARTING TIME <input type="checkbox"/> AM <input type="checkbox"/> PM.	22. IF EMPLOYEE BACK TO WORK GIVE DATE - -		23. AT SAME WAGE YES <input type="checkbox"/> NO <input type="checkbox"/>
	24. IF FATAL INJURY, GIVE DATE OF DEATH. - -	25. DATE EMPLOYER KNEW OF INJURY - -		26. DATE DISABILITY BEGAN - -	27. LAST FULL DAY PAID - DATE -- -	
	28. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.					
INJURY OR DISEASE	29. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.					
	30.. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE WAS USING WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.					
OCCURRENCE	31. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, I.E.					
	32. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED					
	33. NAME OF PHYSICIAN			34. PHYSICIAN'S ADDRESS		
	35. HOSPITAL (IF APPLICABLE)			36. HOSPITAL ADDRESS		

**(THIS SECTION MUST BE COMPLETED IN ORDER TO PROCESS)
 37. WORKERS' COMPENSATION INSURANCE COMPANY NAME, COMPLETE ADDRESS AND TPA (if applicable)**

I.A.B. CODE _ _____

DISTRIBUTION OF THIS REPORT (1 original and 3 copies)

1. ORIGINAL MUST BE SENT IMMEDIATELY TO WORKER'S COMPENSATION INSURANCE CARRIER.
2. COPY TO INDUSTRIAL ACCIDENT BOARD
3. EMPLOYER'S COPY - RETAIN AS RECORD
4. EMPLOYEE'S COPY

SIGNATURE OF PERSON IN 14 ABOVE _____

OFFICIAL POSITION _____

WORKERS' COMPENSATION

IMPORTANT THINGS TO DO IN CASE OF INJURY

THE EMPLOYER SHOULD:

1. Provide all necessary medical, surgical and hospital treatment from the date of accident.
2. Every employer shall keep a record of all injuries received by employees and make a report within 10 days thereof in writing to the Office of Workers' Compensation
3. Ascertain the average weekly wages of the employee and provide compensation in accordance with the provisions of the law, for disability *beyond the third day* after the accident. All agreements as to compensation must be submitted to the Office of Workers' Compensation for approval.

THE EMPLOYEE SHOULD:

1. Immediately notify the employer in writing of accidental injury or occupational disease and request medical services. Failure to give notice or to accept medical services may deprive the employee of the right to compensation.
2. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the law, file application with the Industrial Accident Board for a hearing on the matters at issue within two years of the date of accidental injury or one year of knowledge of the diagnosis of an occupational disease or an ionizing radiation injury. All forms can be obtained from the Office of Workers' Compensation.