EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)

2a. ☐ LOST TIME - ONE OR MORE DAYS

2b. WAS EMPLOYEE PAID FOR 1/2 DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO

3. ☐ LOST EARNINGS BUT NO LOST TIME

4. ☐ MEDICAL/HEALTH CARE

5. ☐ FATALITY DATE OF DEATH: ____ ____ ____ (MM DD YYYY)

6a. ☐ OCCUPATIONAL DISEASE

6b. DATE OF LAST EXPOSURE: _____/_____/_____ (MM DD YYYY)

6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: _____/_____/_____ (MM DD YYYY)

7a. ☐ CORRECT PRIOR REPORT

7b. DATE OF CORRECTION: _____/_____/_____ (MM DD YYYY)

7c. DATE CORRECTION SENT TO WCB: _____/_____/_____ (MM DD YYYY)

EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):

9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): -

10. EMPLOYER NAME:

11. STREET/P.O. BOX MAILING ADDRESS:

12. CITY:

13. STATE:

14. ZIP:

15. TELEPHONE NUMBER:

16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:

17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:

18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:

(check one) ☐ INSURER ☑ THIRD PARTY ADMINISTRATOR (TPA) ☐ SELF-ADMINISTERED EMPLOYER

19. INSURANCE/TPA COMPANY NAME:

20. POLICY NUMBER:

21. INSURER FILE NUMBER:

22. STREET/P.O. BOX MAILING ADDRESS:

23. CITY:

24. STATE:

25. ZIP:

26. TELEPHONE NUMBER: ( )

EMPLOYEE

27. LAST NAME:

28. FIRST NAME:

29. MI:

30. TELEPHONE NUMBER:

31. SOCIAL SECURITY NUMBER:

32. GENDER: ☐ MALE ☐ FEMALE

33. STREET/P.O. BOX MAILING ADDRESS:

34. CITY:

35. STATE:

36. ZIP:

37. DATE OF BIRTH: ____ ____ ____ (MM DD YYYY)

38. OCCUPATION/JOB TITLE:

39. DATE OF HIRE: ____ ____ ____ (MM DD YYYY)

40. WEEKLY WAGE AT TIME OF INJURY: $

41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS:

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ____ ____ ____ (MM DD YYYY)

DATE EMPLOYER NOTIFIED: ____ ____ ____ (MM DD YYYY)

43. DATE OF INCAPACITY: MM DD YYYY

DATE EMPLOYER NOTIFIED: _____/_____/_____ (MM DD YYYY)

44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): AM ☐ PM ☐

46. TIME OF INJURY (e.g. 1:10 p.m.): AM ☐ PM ☐

45. DATE EMPLOYER NOTIFIED INSURER/TPA: _____/_____/_____ (MM DD YYYY)

47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☑ NO
IF YES, GIVE DATE: ____ ____ ____ (MM DD YYYY)

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):

49. BODY PART(s) AFFECTED (e.g. lower right forearm):

50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.):

WAS ACTIVITY PART OF NORMAL JOB DUTIES? ☐ YES ☐ NO

52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO

54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO

55. HEALTH CARE PROVIDER NAME:

56. MAILING ADDRESS: Medical Provid

57. TELEPHONE NUMBER:

PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OF PRINT):

59. TELEPHONE NUMBER:

60. DATE SENT TO WCB: ____ ____ ____ (MM DD YYYY)

WCB-1 (1/02) The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services or activities. This material can be made available in alternate formats by contacting your Department ADA Coordinator.

DISTRIBUTION: COPY (1) MAINE WORKERS' COMPENSATION BOARD, 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER