MN Department of Labor and Industry Workers' Compensation Division PO Box 64221 St. Paul, MN 55164-0221 (651) 284-5032 or 1-800-342-5354

First Report of Injury See Instructions on Reverse Side

PRINT IN INK or TYPE ENTER DATES IN MM/DD/YYYY FORMAT



Fax: (651) 284-5731					AIES	S IIN I	VIIVI/DD/	YYYYFO	ORIV	IA I		DO N	OT U	SE THIS	SPA	CE		
1. EMPLOYEE SOCIA	SHA case	#				oyee began												
					WOIK	on date of inju		<i>'</i>		pm								
4. DATE OF CLAIMED INJURY 5. Time of injury				am	6. Da	ate of	death	ath # of depender is related to in			ath							
				pm				13 TCIAC	ica io	iiijaiy)								
7. EMPLOYEE Name (last, suffix, first, middle) 8. Gend								9. Marital status		Married								
						M	1 L F	Status		Unmarri	ed							
10. Home address						11. Home phone #				12. Date	12. Date of birth				13. Date hired			
City. Chata Zin Cada					14 000			···· atian			45. Danislandan arturant			10. A				
City State Zip Code					14. Occu			pation			15. Regular departm							
17. Average weekly wage 18. Rate per 19. Hours) Dav	s ner	Normal	ormal work schedule		Sun - Sat	21 Fm	1. Employment		Yes	片	No		
hour day			week			S M	S M T W T			status	(check all	一	ull time	一	Part time			
22. Tell us how the injury/illness occurred, what the employ			vee was	ree was doing before			ent (give d	letails), and what	that ap			Seasonal moles: "W		Volunteer			
lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."																		
	23. What was the injury or illness (include the part(s) of body)? Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist. 24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.															•		
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05 0:1:				00	- :				-			1 10			(DOI)			
25. Did injury occur on employer's premises?				26.	26. First date of an			y lost time		7. Employe Yes		r lost time on day of injury (DOI) No No lost time on DOI						
Yes No Name and address of the place of the occurrence				28 1	Data a	mnlov	er notified	l of injuny	20	9. Date employer notified of lost time					וטטו			
Traine and address of the place of the eccuments					Date 6	проу	rei notinet	notified of injury 29.			oloyer in	otilied of it	ot unic					
				30. I	Return	to wo	ork date	date 31			ne empl	over	32. RT	W with re	strictio	ns		
											Yes No			Yes No				
33. Treating physician (name) 34					Extent	of me	dical trea	al treatment (check all t			<u></u>			_				
None								finor on-site by employer's medical staff Minor clinic/hospital										
35. Certified Managed	room	Hospita	alizati	ion more th	nan 24 h	ours												
	or medica	anticipate	ed															
36. EMPLOYER Legal	name						37. E	MPLOYER	R DB	A name (if	different)						
38. Mailing address							39. E	mployer F	EIN	40. Une			mployment ID #					
City State Zip Code								41. Employer's contact name and phone #										
42 Physical address ((if different)						42 \	litacca (na	2000	and phone)	if more	than 1 at	took o	onarata (shoot			
42. Physical address (if different)							43. VV	43. Witness (name and phone) - if more than 1 attach a separate sheet										
City State Zip Code							44. N	AICS code	e			45. Date	form co	mpleted				
														,				
46. INSURER name							51. C	LAIMS A	DMIN	COMPAN	Y (CA) 1	name (che	ck one))	П.	nsurer		
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47. Insured legal name and FEIN								Δ address	•						ш'	PA		
11. House logal hame and I Lift							32. 0	52. CA address										
48. Policy # (including effective dates) or self-insured certificate #								City State Zip Code										
		, 55.1	2 2 3 2 0				,											
49. Insurer FEIN 50. Date insurer received					d notic	e	53. C	A FEIN		54. CA			elaim #					
55. To be completed	Claim type c	ode.	Type of	loss co	de.	l a	ate reasor	code.	9	Salary paid	in lieu o	f comp?	Death	result of	iniurv'	?		
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GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dii.mn.gov.

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within ten days. Your insurer may require you to file it sooner. Failure to file within the ten days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. Your insurer will report the injury to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY - DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to
 work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury
 after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see <a href="www.usa.gov/Business/Busines
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR

The following data elements must be completed on this form prior to filing with the Department of Labor and Industry: employee's name and social security number; date of injury; and the names of the employer and insurer. If any of this information is missing, the First Report will be rejected and returned to you (see Minn. Stat. § 176.275). Providing the name of the third party administrator does not meet the statutory requirement to provide the name of the insurer. NOTE: If the claim does not involve lost time beyond the waiting period or potential PPD, the form does **NOT** need to be filed with the Department.

- Item 46: Fill in the name of the insurance company. If the employer is self-insured, indicate the name of the licensed or public self-insured company or group.
- Items 47-48: Fill in the legal name and Federal Employer Identification Number (FEIN) of the employer who purchased the policy from the insurer (named in Item 46) and the policy number. If the employer is licensed to self-insure, fill in the certificate number.
- Item 49: Fill in the insurer's FEIN.
- Item 51: Fill in the name and address of the company administering the claim (either the insurer or third party administrator). Be sure to mark either the "Insurer" or "TPA" box.
- Item 53-54: Fill in the claims administrator's FEIN and claim number.
- Item 55: These items apply only to FROIs electronically submitted by the claim administrator.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.