Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5030

First Report of Injury

See Instructions on Reverse Side.
Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA Case #		
3. DATE OF CLAIMED INJURY	4. Time of injury am pm	5. Time employee began work on date of injury am pm	
6. EMPLOYEE Name (last, first, middle)	7. Gender M F	8. Marital Status Married Unmarried	
9. Home address	10. Home phone #	11. Date of birth	
City State Zip Code	12. Occupation	13. Regular department	14. Date hired

15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week	19. Employment Status: Full time, Seasonal, Part time, Volunteer
20. Weekly value of: Meals	Lodging	2nd income		21. Apprentice Yes No

22. **Tell us how the injury occurred and what the employee was doing before the incident (give details).** *Examples: "Worker was driving 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.*

25. Did injury occur on employer's premises? Yes No If no, indicate name and address of place of occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) Yes No No lost time on DOI
	28. Date employer notified of injury	29. Date employer notified of lost time
	30. Return to work date	31. Date of death

32. TREATING PHYSICIAN (name, address, and phone)	33. HOSPITAL/CLINIC (name and address) (if any)	34. Emergency Room Visit Yes No
		35. Overnight in-patient Yes No

36. **EMPLOYER** Legal name		37. EMPLOYER DBA name (if different)	
38. **Mailing** address		39. Employer FEIN	40. Unemployment ID #
City State Zip Code		41. Employer's contact name and phone #	
42. **Physical** address (if different)		43. Witness (name and phone)	
City State Zip Code		44. NAICS code	45. Date form completed
46. **INSURER** name		**51. CLAIMS ADMIN COMPANY** (CA) name (check one) Insurer TPA	
47. Insured legal name		52. CA Address	
48. Policy # or self-insured certificate #		City State Zip Code	
49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. Claim #

GENERAL INSTRUCTIONS TO THE EMPLOYER

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 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. Self-insured employers have 14 days to file this form with the Department of Labor and Industry (Department). It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will forward a copy of this form** to the Department, if 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 within **seven** days of the occurrence.

Employers are required to complete this form. Each piece of information is needed to determine liability and entitlement to benefits. Failure to complete the form may result in delayed processing and possible penalties. 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's web site at www.dli.mn.gov. Employees are not responsible for completing this form.

SEND REPORT TO INSURER IMMEDIATELY – DO NOT WAIT FOR DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS FOR 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 15-20: 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.
- 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 notify your insurer if the employee misses time due to this injury after that date.
- Item 39: Fill in your Federal Employment ID number (FEIN). For information on this number, see www.firstgov.gov and click on Employer ID Number under Business.
- 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.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR/SELF-INSURED EMPLOYER

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 (per 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 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 Federal Employment ID number (FEIN) number.
- 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.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/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.

SUPERVISOR'S REPORT OF ACCIDENT

(PLEASE READ AND FOLLOW INSTRUCTIONS ON BACK)

EVERY ACCIDENT SHOULD BE INVESTIGATED AND THE CAUSES CORRECTED SO THAT MORE ACCIDENTS WILL NOT OCCUR. DO NOT OVERLOOK THE SO-CALLED "UNIMPORTANT" CASES, BECAUSE, EXCEPT FOR "CHANCE" THEY COULD ALSO HAVE BEEN SERIOUS. IT IS ONLY BY THOROUGH INVESTIGATION THAT MANY OF THE REAL CAUSES CAN BE DETERMINED AND CORRECTED.

NAME OF EMPLOYEE ______________________ COMPANY ______________________ DEPT. ____________

DATE OF ACCIDENT ______________ TIME __________ DID EMPLOYEE LOSE TIME FROM WORK? YES NO

HOURS LOST ON DATE OF ACCIDENT ______________________ HAS EMPLOYEE RETURNED TO WORK? YES NO

JOB TITLE ______________________ SERVICE WITH THE COMPANY __________ YEARS IN PRESENT JOB ______

GIVE US YOUR HONEST COMMENTS ON QUESTIONS BELOW. WE ARE NOT TRYING TO BLAME ANYONE. YOUR OPINION MAY HELP US PREVENT ACCIDENT REPETITION.

PLEASE ANSWER THE FOLLOWING: **CHECK "YES" OR "NO"**

1. WAS INJURED PERSON PROPERLY INSTRUCTED IN SAFE AND EFFICIENT METHODS? .... YES NO
2. DID INJURED PERSON VIOLATE ANY INSTRUCTIONS?.. NO YES
3. WAS NECESSARY PROTECTIVE EQUIPMENT WORN? (IF APPLICABLE) .... YES NO
4. DID POOR HOUSEKEEPING CONTRIBUTE TO INJURY? .... NO YES
5. DID HORSEPLAY CAUSE THE INJURY? .... NO YES
6. WAS IT CAUSED BY SOMETHING WHICH NEEDED REPAIRS? .... NO YES
7. SHOULD A GUARD BE PROVIDED? .... NO YES
8. DID ANY BODILY DEFECT CONTRIBUTE TO INJURY? .... NO YES
9. WAS IT CAUSED BY AN UNSAFE ACT? .... NO YES
10. DID INJURED REPORT THE INJURY TO YOU, THE SUPERVISOR, IMMEDIATELY? .... YES NO

ACCIDENT. (DESCRIBE WHAT INJURED WAS DOING AT TIME OF ACCIDENT, WHAT HAPPENED, WHO WAS INVOLVED, NATURE OF INJURY, PART OF BODY AFFECTED.)

WITNESSES' NAMES

UNSAFE ACTS. (WHAT DID THE EMPLOYEE OR ANOTHER PERSON DO INCORRECTLY?)

UNSAFE CONDITIONS. (WHAT UNGUARDED OR UNSAFE CONDITION OF MACHINERY, EQUIPMENT, BUILDING OR PREMISES WAS INVOLVED?)

ACTIONS TAKEN. (WHAT DID YOU DO TO CORRECT THE CONDITIONS WHICH CAUSED THIS INJURY?)

REMEDIES. (WHAT SHOULD YOUR ORGANIZATION DO TO PREVENT OTHER INJURIES LIKE THIS?)

MEDICAL CARE. DID EMPLOYEE GO TO DOCTOR OR HOSPITAL? YES NO IF YES, COMPLETE THE FOLLOWING

NAME OF DOCTOR OR HOSPITAL ______________________________ DATE OF INITIAL VISIT ____________

ADDRESS ______________________________ TELEPHONE NUMBER ____________

AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION? YES NO

REASONS WHY

REPORT SUBMITTED BY ______________________________ DATE ____________

COMPLETION INSTRUCTIONS FOR SUPERVISORS' REPORT OF ACCIDENT (SRA)

The primary purpose of the SRA is to investigate the accident. It is also used to report the accident to the central office where the First Report of Injury is then completed by administrative personnel. The SRA should be filled out as soon as possible after the accident.

The SRA is incomplete or delayed, corrective action may also be delayed. A delay in taking corrective action will probably result in the occurrence of a similar accident.

The initial information asked for at the top of the SRA concerning the injured person's name, occupation, age job history and loss of time from work is self-explanatory, but very necessary for eventual completion of the First Report of Injury.

The following is a line-by-line set of instructions for completing of the SRA by the **Supervisor** of the injured employee. Concrete examples of important parts of the form are given for your use. This report should not be completed by the injured employee.

QUESTIONS

1. Was proper instruction given to the employee on how to do the job safely? Supervisors should instruct their employees on how to do the job efficiently and safely.

2. Referred to in question #1.

3. The supervisor should have told the employee what personal protective equipment is necessary to do the job. Did the employee wear the personal protective equipment when this job was being done?

4. Was the work area clean and well organized? i.e., scraps on the floor, blocked aisles, wet floor, spilled food, etc.

5. Was there inadequate supervision? Did horseplay or practical jokes contribute to the accident?

6. Was the injured person using equipment that was unsafe and in need of repair? i.e., broken ladder, bad electric cord on drill, etc.

7. Would a guard prevent another accident from happening? i.e., guard around the belts and pulleys, railing properly in place, guard on saw, etc.

8. Did this person have any bodily defects which might have helped cause the accident? i.e., poor vision, previous back injury, etc.

9. Most injuries are caused in part by unsafe acts. An Unsafe Act is something that the injured person or another person did, that he or she should not have done, which led to the accident. Below is a list of the most common unsafe acts and contributing factors:

    1. Operating without authority
    2. Failure to warn or secure
    3. Operating at unsafe speed
    4. Making safety devices inoperative
    5. Using equipment, tools, materials or vehicles unsafely
    6. Using defective equipment, materials, tools or Vehicles
    7. Failure to use personal protective equipment
    8. Failure to use equipment provided (except personal protective equipment)
    9. Unsafe loading, placing and mixing
    10. Unsafe lifting and carrying (including insecure grip)
    11. Taking an unsafe position
    12. Adjusting, clearing jams, cleaning machinery in motion
    13. Distracting, teasing
    14. Poor housekeeping practices
    15. Disregard of instructions
    16. Lack of knowledge or skill
    17. Act of other than injured
    18. Others...................

10. The accident should have been reported immediately to the supervisor; was it?

Accident

1. Describe what the injured was doing at the time of the accident. .
2. What happened? .
3. Who was involved?
4. What injuries resulted?

Example: John was drilling a hole in the ceiling and chips of plaster fell into his eye. (This answers questions 1 and 2.) John got chips of plaster in his eye resulting in a scratch to his eye. John was wearing his prescription glasses. (This answers questions 3 and 4.)
Note the names of witnesses, if any.

Unsafe Act

efer to question 9 above and examples of Unsafe Acts. Example: John was not wearing proper personal protective equipment.

Unsafe Conditions

1. Defective tools, equipment, substances
2. Unsafe design or construction
3. Hazardous arrangement
4. Improper illumination
5. Improper ventilation
6. Improper dress
7. Poor housekeeping
8. Congested area
9. Other

Action Taken Example: John has been re-instructed to wear proper personal protective equipment such as goggles or face shield when drilling overhead.

Remedy Example: Standard safety policy should be adopted that requires use of personal protective equipment. This policy should be strictly enforced by the supervisors.

Medical Care: Include all medical information that is known at this time. Do not delay the completion of this form for more complete information.

As supervisor, do you feel that this injury should be covered under workers' compensation benefits? As a general rule, if the employee is injured while at work, that injury is covered under workers' compensation. However, if you as supervisor, have reason to suspect that the injury did not occur at work, please tell us. This is only an opinion and by itself will not deny benefits.