



INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION									
Social Security number	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown			Occupation / Job title			NCCI class code	
Name (last, first, middle)			Marital status <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		Date hired	State of hire		Employee status	
Address (number and street, city, state, ZIP code)				Number of dependents		Hrs / Day	Days / Wk	Avg Wg / Wk	<input type="checkbox"/> Paid Day of Injury <input type="checkbox"/> Salary Continued
Telephone number (include area code)						Wage	Per	<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year <input type="checkbox"/> Other	
EMPLOYER INFORMATION									
Name of employer				Employer ID#		SIC code		Insured report number	
Address of employer (number and street, city, state, ZIP code)				Location number		Employer's location address (if different)			
				Telephone number					
				Carrier / Administrator claim number		OSHA log number		Report purpose code	
Actual location of accident / exposure (if not on employer's premises):									
CARRIER / CLAIMS ADMINISTRATOR INFORMATION									
Name of claims administrator				Carrier federal ID number		Check if appropriate <input type="checkbox"/> Self Insurance			
Address of claims administrator (number and street, city, state, ZIP code)				<input type="checkbox"/> Insurance Carrier		Policy / Self-insured number			
Telephone number				<input type="checkbox"/> Third Party Admin.		Policy period From _____ To _____			
Name of agent				Code number					
OCCURRENCE / TREATMENT INFORMATION									
Date of Inj. / Exp.	Time of occurrence <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Cannot be determined		Date employer notified	Type of injury / exposure				Type code	
Last work date	Time workday began	Date disability began		Part of body				Part code	
RTW date	Date of death	Injury / Exposure occurred on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of contact			Telephone number		
Department or location where accident / exposure occurred				All equipment, materials, or chemicals involved in accident					
Specific activity engaged in during accident / exposure				Work process employee engaged in during accident / exposure					
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.									Cause of injury code
Name of physician / health care provider									
Hospital or offsite treatment (name and address)							INITIAL TREATMENT <input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinic / Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/> Future Major Medical / Lost Time Anticipated		
Name of witness			Telephone number		Date administrator notified				
Date prepared	Name of preparer		Title		Telephone number				

An employer's failure to report an occupational injury or illness may result in a \$50 fine (IC 22-3-4-13).