

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE					
1. Insured Report Number		2. Filing Office Claim Number		3. OSHA Log Case Number	
EMPLOYER					
4. Employer Business Name			ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1			10. Mailing Address 1		
6. Physical Address 2			11. Mailing Address 2		
7. City		8. State	9. Zip		12. City
					13. State
					14. Zip
15. Federal ID Number		16. U.C. Account Number		17. NAICS	
INSURER / FILING OFFICE					
18. Insurer Name			21. Filing Office Name		
19. Insurer Federal ID Number			22. Mailing Address 1		
20. Type Insurer			23. Mailing Address 2 or Telephone Number		
Ins Co <input type="checkbox"/>			24. City		
Self-Insurer <input type="checkbox"/>			25. State		
Group Fund <input type="checkbox"/>			26. Zip		
			27. Filing Office Federal ID Number		
EMPLOYEE / WAGES					
28. First Name			32. Employee ID Number		
29. Middle Name			33. Type Employee ID Number		
30. Last Name			SSN <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)			Passport Number <input type="checkbox"/>		
			Green Card <input type="checkbox"/>		
			Employment Visa <input type="checkbox"/>		
			Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1			40. Gender		41. Date of Birth
35. Mailing Address 2			Male <input type="checkbox"/>		
36. City			Female <input type="checkbox"/>		42. Nbr of Dependents
37. State			38. Zip		44. Date Hired
39. Phone					
43. Marital Status					
Unmarried (Single or Divorced or Widowed) <input type="checkbox"/>					
Married <input type="checkbox"/>					
Separated <input type="checkbox"/>					
Unknown <input type="checkbox"/>					
45. Occupation Description				46. Number of Days Worked Per Week	
47. Wages \$			49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
48. Hourly <input type="checkbox"/>			50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Daily <input type="checkbox"/>					
Weekly <input type="checkbox"/>					
Bi-weekly <input type="checkbox"/>					
Monthly <input type="checkbox"/>					
INJURY / TREATMENT					
51. Date of Injury		52. Time of Injury		53. Time Employee Began Work	
		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
54. Date Disability Began				55. Date of Death	
PLACE OF ACCIDENT, INJURY, OR EXPOSURE				61. Injury Occurred on Employer's Premises?	
56. Site Address				Yes <input type="checkbox"/> No <input type="checkbox"/>	
57. City		58. State		59. Zip	
60. County				62. Date Employer Notified	
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)					
<p>PROVIDE DESCRIPTION CODES to identify Nature of Injury, Part of Body that was affected, and Cause of Injury. (FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC</p>					
64. Nature of Injury Code			65. Part of Body Code		66. Cause of Injury Code
67. Initial Treatment		No Medical Treatment <input type="checkbox"/>		68. Name of Treatment Facility	
First Aid By Employer <input type="checkbox"/>		Minor Clinic / Hospital <input type="checkbox"/>		69. Address	
Emergency Room <input type="checkbox"/>		Hospitalized Overnight <input type="checkbox"/>		70. City	
Hospitalized > 24 Hours <input type="checkbox"/>		Outpatient Treatment <input type="checkbox"/>		71. State	
73. Name of Physician or Other Health Care Professional				74. Has Injured Returned to Work	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				If so, 75. Date	
				76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
OTHER					
77. Date Prepared	78. Preparer's First Name		79. Last Name		80. Title
					81. Preparer's Telephone Number