



# 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 checked="" type="checkbox"/> Insurance Carrier		Policy / Self-insured number				
Telephone number				<input type="checkbox"/> Third Party Admin.		Policy period		From		To
Name of agent McGowan Insurance Group, Inc.				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).