



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 <input type="checkbox"/> Paid Day of Injury <input type="checkbox"/> Salary Continued			
Address (number and street, city, state, ZIP code)			Hrs / Day	Days / Wk	Avg Wg / Wk				
Telephone number (include area)		Number of dependents		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 <input type="checkbox"/> Third Party Admin.		Policy / Self-insured number				
Telephone number					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).