

First Report of Injury

See Instructions on Reverse Side



FR01

PRINT IN INK or TYPE
 ENTER DATES IN MM/DD/YYYY FORMAT

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #		2. OSHA case #		3. Time employee began work on date of injury <input type="checkbox"/> am <input type="checkbox"/> pm	
4. DATE OF CLAIMED INJURY		5. Time of injury <input type="checkbox"/> am <input type="checkbox"/> pm		6. Date of death # of dependents (if death is related to injury)	
7. EMPLOYEE Name (last, suffix, first, middle)				8. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
				9. Marital status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried	
10. Home address			11. Home phone #		12. Date of birth
City		State		Zip Code	
14. Occupation			15. Regular department		16. Apprentice <input type="checkbox"/> Yes <input type="checkbox"/> No
17. Average weekly wage		18. Rate per hour	19. Hours per day	20. Days per week	21. Employment status (check all that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer
22. Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Name and address of the place of the occurrence		26. First date of any lost time		27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI	
		28. Date employer notified of injury		29. Date employer notified of lost time	
		30. Return to work date		31. RTW same employer <input type="checkbox"/> Yes <input type="checkbox"/> No	32. RTW with restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No
33. Treating physician (name)		34. Extent of medical treatment (check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Minor on-site by employer's medical staff <input type="checkbox"/> Minor clinic/hospital <input type="checkbox"/> Emergency room <input type="checkbox"/> Hospitalization more than 24 hours <input type="checkbox"/> Future major medical anticipated			
35. Certified Managed Care Organization (if any)					
36. EMPLOYER Legal name			37. EMPLOYER DBA name (if different)		
38. Mailing address			39. Employer FEIN		40. Unemployment ID #
City		State		Zip Code	
42. Physical address (if different)			43. Witness (name and phone) - if more than 1 attach a separate sheet		
City		State		Zip Code	
44. NAICS code			45. Date form completed		
46. INSURER name			51. CLAIMS ADMIN COMPANY (CA) name (check one) <input type="checkbox"/> Insurer <input type="checkbox"/> TPA		
47. Insured legal name and FEIN			52. CA address		
48. Policy # (including effective dates) or self-insured certificate #			City		State Zip Code
49. Insurer FEIN		50. Date insurer received notice		53. CA FEIN	
				54. CA claim #	
55. To be completed by the CA:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. 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 of Labor and Industry's web site at www.dli.mn.gov.

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

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON 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 17-21: 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. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- 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 answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see www.usa.gov/Business/Business-Gateway.shtml and click on "Get an Employer ID Number".
- 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 if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR

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 (see 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 and Federal Employer Identification Number (FEIN) 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 FEIN.
- 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.
- Item 55: These items apply only to FROIs electronically submitted by the claim administrator.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 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.