



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

State Form 34401 (R9 / 3-01)

| 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) | | | Hrs / Day | Days / Wk | Avg Wg / Wk |
| Telephone number (include area code) | | 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 | | | 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 | |
| | | Policy period From | To |
| Telephone number | Code number | | |
| Name of agent | | | |

| OCCURRENCE / TREATMENT INFORMATION | | | | | |
|---|---|--|---|--|--|
| Date of Inj./ Exp. | Time of occurrence <input type="checkbox"/> AM <input type="checkbox"/> PM | 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 | | | | | 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).