State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Date filed in Chairman's Office

(for WCC use only)

Employer *(Name, Address & Zip)* | Phone #

SIC Code | FEIN

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ☐ Check, if Self-Insured

Policy Period *(MM/DD/YY)*
FROM: TO:

Employee: Last Name First Name Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender
☐ Male
☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ _____ . _____ per
☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ☐ a.m. ☐ p.m.

Time of Occurrence ☐ cannot be determined ☐ a.m. ☐ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Contact Name

Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ☐ Yes ☐ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

If provided, were they used? ☐ Yes ☐ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

☐ No Medical Treatment
☐ Emergency Care
☐ Minor — by Employer
☐ Hospitalized More Than 24 Hours
☐ Minor — by Clinic / Hospital
☐ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 7-13-2009

1A

Filing Status and Exemption

This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER October 1, 1991, and must be completed in its entirety.

WCC File #

Date filed in District

(for WCC use only)

EMPLOYEE

Name _____ Date of Birth *(required)* _____

Address _____

City/Town _____ State _____ Zip Code _____

DATE OF INJURY:

_____

FILING STATUS AND EXEMPTIONS — In order to determine your weekly benefit rate, as per Sec. 31-310 C.G.S.,we need the following information:

1. Select your Federal tax filing status based upon your **ACTUAL filing status as of the date of injury**, listed at right: *(Must match your tax return, as if you were filing with the IRS on the date of your injury.)*

   ❑ Single ❑ Head of Household ❑ Married filing jointly ❑ Married filing separately

2. Number of exemptions *(including yourself)* as of the date of injury listed at right = _____

3. FICA withheld for the above-named employee? ..... ❑ YES ..... ❑ NO — ***If NO, insurer must manually calculate weekly benefit rate.***

4. Check all appropriate boxes:

   ❑ Employee 65 years of age or older ❑ Employee legally blind ❑ Spouse 65 years of age or older ❑ Spouse legally blind

5. List name *(yourself first)*, date of birth, and relationship to you for all exemptions included in question #2, above:

Name	*Date of Birth*	*Relationship*
		SELF

CONCURRENT EMPLOYMENT — To be certain you receive all the benefits to which you are entitled, provide the following information *if you were working for more than one employer on the date of injury indicated above*:

Name of Employer	*Address*	*Date of Hire*

NOTE: Wage information for each concurrent employer must be supplied by the claimant.

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

I hereby attest that the above information is correct to the best of my knowledge.

Employee's Signature _____ Date _____

State of Connecticut Workers' Compensation Commission

This form prepared by the WCC is proper for ordinary use and is recommended, but any other notice complying with Section 31-294c shall be deemed sufficient.

Rev. 10-01-2021

30C

WCC File #

Date filed in District

(for WCC use only)

Notice of Claim for Compensation

(Employee to Administrative Law Judge and to Employer)

Notice is hereby given that the injured worker, while in the employ of the employer, sustained injuries arising out of and in the course of his/her employment as follows, and makes claim for compensation benefits.

Please TYPE or PRINT IN INK

INJURED WORKER

Name _____
(first) *(middle)* *(last)*

D.O.B. *(required)* _____

Check, if a Minor ❑ *(under 18 yrs. of age)*

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

EMPLOYER

Employer _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

Was Injury ON Premises of Employer? ❑ YES ❑ NO

If NO, where? _____

Address _____

Town _____

Zip Code _____ Tel.# _____

INJURY

Date of Injury _____

Town of Injury _____

Body Part(s) _____

Describe Injury and How It Happened:

❑ Check, if an Occupational Disease or a Repetitive Trauma

❑ Check, if you have MORE THAN ONE Employer

❑ Check, if PTSD pursuant to P.A. 19-17 (police officer, parole officer, firefighter)

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

Signature _____

Date _____

Print name & address below, if other than injured worker:

Name _____

Name of Firm _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

This notice must be served upon the Administrative Law Judge and *Employer by personal presentation or by registered or certified mail. For the protection of both parties, the employer should note the date when this notice was received and the claimant should keep a copy of this notice with the date it was served.

* *Persons employed by the State of Connecticut must serve the employer by serving this notice upon the Commissioner of Administrative Services, 450 Columbus Boulevard, Hartford, CT 06103.*

* *Persons employed by a municipality must serve the employer by serving this notice upon the town clerk of the municipality in which he or she is employed.*

* *If your employer pursuant to statute has posted the location where this notice is to be filed, it is your obligation to file it at that location, using certified mail.*

WARNING: If an employer does not file a notice contesting liability (e.g. Form 43) for this claim OR begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date when this claim is received by personal delivery or by registered or certified mail, COMPENSABILITY SHALL BE PRESUMED and cannot thereafter be contested. If an employer chooses to begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date of receipt of this claim and still wishes to contest this claim, it must do so by filing a notice contesting liability for this claim within one year from receipt of this claim [See Sec. 31-294c(b)] OR, in the case of a claim for PTSD pursuant to P.A. 19-17, within 180 days.

A 30C Form should be filed promptly after a work-related injury or illness takes place. There is a statute of limitation for filing workers' compensation claims: within **one** year of the date of an accidental injury or within **three** years from the first manifestation of a symptom of an occupational disease.

[**NOTE**: If, within the applicable time period described above, (1) there has been a hearing or a written request for a hearing or an assignment for a hearing or (2) your employer's insurance carrier has already signed a Voluntary Agreement, you do **NOT** need to file a 30C Form for the injury or illness it covers.]

You Should File A 30C Form Because . . .

- There will be no doubt that you are claiming that you have a work-related injury or occupational disease.
- It is the best way to insure that you have met the statute of limitations for filing a workers' compensation claim.
- A simple "accident report" filed with the employer is not an official claim for workers' compensation.
- Your claim will be more likely to receive prompt attention from your employer or insurance carrier.
- Once your employer receives an official claim, they have only 28 calendar days in which to either deny your claim or to begin making workers' compensation benefit payments "without prejudice." If an official denial is not issued within 28 calendar days or if benefit payments are not initiated within 28 calendar days, your employer must accept the compensability of your claim. (If your employer has opted to post a location where you must file your claim, this 28-day period begins when your employer has received your claim *at the location posted* per statute.)

Directions for Completing the 30C Claim Form

Please pay close attention to these directions. Remember to Type or Print Neatly In Ink (except for signatures).

In filling out the 30C Form, please note the following:

1. **In the "INJURED WORKER" box** at the upper left side of the form, **type or neatly print the name of the injured worker (If YOU are the injured worker, print YOUR name here.). Also fill in the injured worker's D.O.B.** (date of birth), **put a check in the box if the worker is a minor** (under the age of 18), **and fill in the injured worker's street address, town, state, zip code, and telephone number**.
2. **In the "EMPLOYER" box** at the lower left side of the form, **type or neatly print the name of the employer** ("Name of employer" means the name of the organization for which you work, NOT your boss or supervisor.) **and its street address, town, state, zip code, and telephone number**. **Next indicate** (YES or NO) **whether the injured worker's injury occurred at the employer's location just listed; *if the injury took place at a location other than that listed*, fill in the location, street address, town, state, zip code, and telephone number where the injury actually occurred**.
3. **In the "INJURY" box** at the upper right side of the form, **type or neatly print the date of the injured worker's injury and the town in which the injury occurred** (Note the city or town in which the injury actually occurred. This will not necessarily be the same location as the employer's business address!). I**ndicate the part(s) of the worker's body injured and how the injury occurred** (In the blank space describe your injury in simple terms, specifying the part(s) of your body affected and the type(s) of injury. For example: "sprain to the right shoulder", "amputation of the left thumb", "fracture of the right ankle", "severe strain to lower back", etc.). **Next check the first box**, *if the injury is an occupational disease or a repetitive trauma*, **check the second box** *if you have more than one employer*, **and check the third box** *if you are a police officer, parole officer, or firefighter claiming benefits for PTSD pursuant to Public Act 19-17*.
4. **In the "SIGNATURE OF INJURED WORKER OR REPRESENTATIVE" box** at the lower right side of the form, **sign your name and fill in the date of your signature, if you are the injured worker. *If you are NOT the injured worker*, then sign your name, fill in the date of your signature, and then type or neatly print your name, the name** (if any) **of your firm, your street address, town, state, zip code, and your telephone number**.
5. **In the "WCC File #" box** at the upper right side of the form (just below the "30C" number in the upper right corner), **type or neatly print the WCC File Number, ONLY IF YOU KNOW IT**. In most instances, this number will be assigned to your claim by the Workers' Compensation Commission only after you send the 30C Form in, so **it is okay to leave this one area of the form blank, if you are not absolutely sure of the number**.

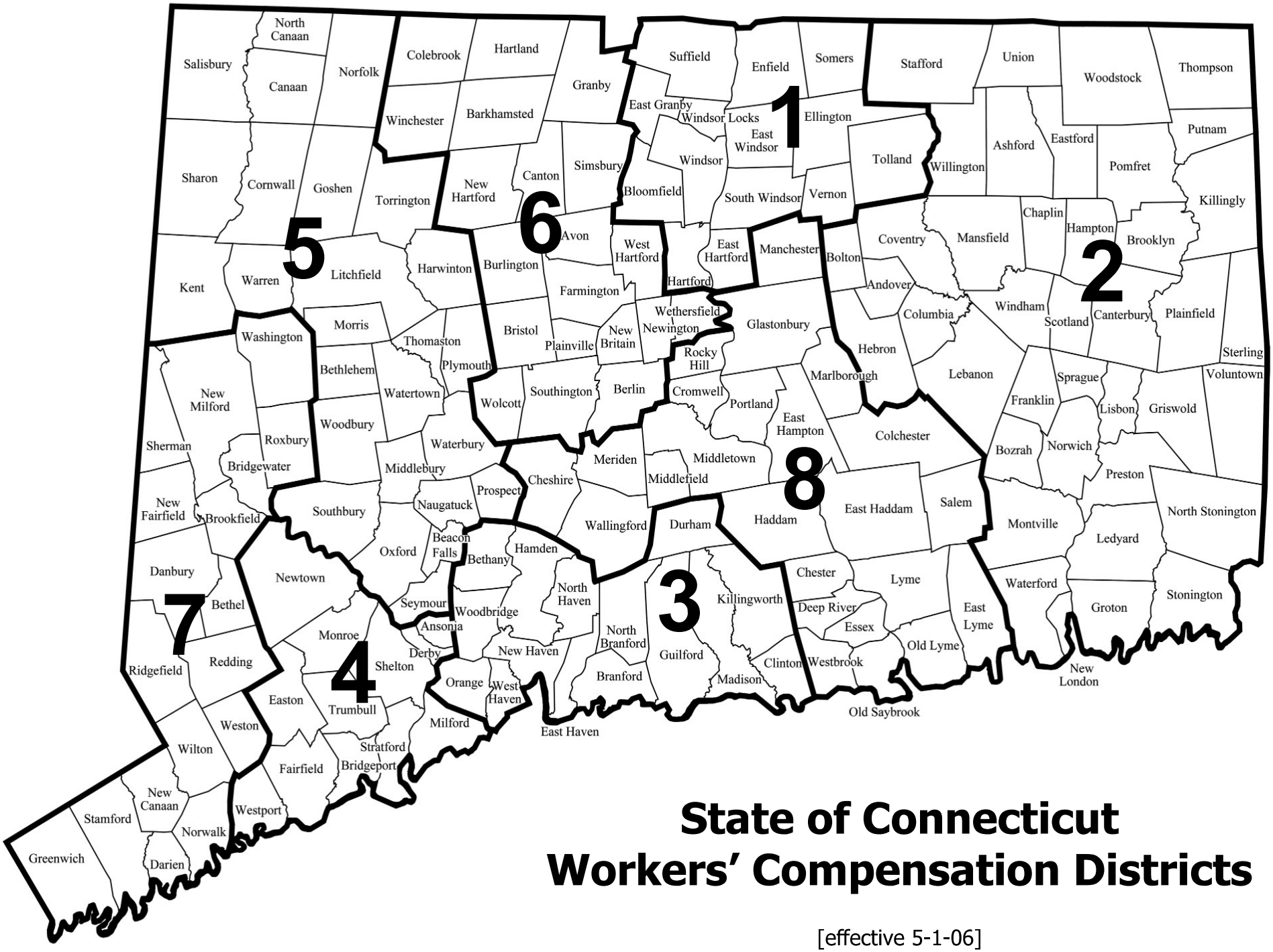
Once you have completed the 30C Form, follow these procedures:

6. **Make two (2) extra copies of your completed 30C Form** (this can be done at many quick-copy printers).
7. **Send the original 30C to your employer* by Certified or Registered mail, return receipt requested. The claim may also be delivered in person but if so, have the employer acknowledge in writing the receipt of the claim.**

   **** State employees'** work-related injuries and illnesses are reported on Form PER-WC 207, entitled "Report of Occupational Injury or Disease to an Employee". If a State employee elects to file a 30C Form, then he or she must send the 30C Form to the Commissioner of Administrative Services, 450 Columbus Boulevard, Hartford, CT 06103, NOT to the particular office where employed. (The Form PER-WC 207 is ONLY an accident report and is NOT the official claim form for workers' compensation benefits — State employees, like any other employees, must file a 30C Form in order to file an official workers' compensation claim.)*

   **** Municipal employees**, like any other employees, must file a 30C Form in order to file an official workers' compensation claim; if a municipal employee elects to file a 30C Form, then he or she must send the 30C Form to the town clerk of the municipality in which he or she is employed.*

   **** Employees (other than State or municipal employees):** if your employer pursuant to statute has posted the location where you must file a 30C Form, it is your obligation to file it at that location, using certified mail.*
8. **Send a copy of the 30C to the appropriate Workers' Compensation Commission District Office by Certified or Registered mail, return receipt requested, or deliver by personal presentation.** Addresses for all Workers' Compensation Commission District Offices may be found in this packet of material. **The "District Office"refers to the number given to the District Workers' Compensation Commission Office for the town in which you were injured**. Refer to the Connecticut map provided with the Form 30C for the number of the Compensation District for the town in which you were injured.
9. **Keep the remaining copy of the 30C for your own file.**



State of Connecticut
Workers' Compensation Districts

[effective 5-1-06]

Workers' Compensation Commission District Offices

District 1 — Hartford

999 Asylum Avenue
Hartford, CT 06105

Phone: (860) 566-4154
Fax: (860) 566-6137

District 2 — Norwich

55 Main Street
Norwich, CT 06360

Phone: (860) 823-3900
Fax: (860) 823-1725

District 3 — New Haven

700 State Street
New Haven, CT 06511-6500

Phone: (203) 789-7512
Fax: (203) 789-7168

District 4 — Bridgeport

350 Fairfield Avenue
Bridgeport, CT 06604

Phone: (203) 382-5600
Fax: (203) 335-8760

District 5 — Waterbury

55 West Main Street
Waterbury, CT 06702

Phone: (203) 596-4207
Fax: (203) 805-6501

District 6 — New Britain

24 Washington Street
New Britain, CT 06051

Phone: (860) 827-7180
Fax: (860) 827-7913

District 7 — Stamford

111 High Ridge Road
Stamford, CT 06905

Phone: (203) 325-3881
Fax: (203) 967-7264

District 8 — Middletown

90 Court Street
Middletown, CT 06457

Phone: (860) 344-7453
Fax: (860) 344-7487

State of Connecticut Workers' Compensation Commission

This form prepared by the WCC is proper for ordinary use and is recommended, but any other notice complying with Section 31-294c shall be deemed sufficient.

To be filed by dependent of deceased employee, or legal representative of such dependent, following the work-related death of employee. ATTACH DEATH CERTIFICATE, if available.

Rev. 10-01-2021

30D

WCC File #

Date filed in District

(for WCC use only)

Dependent's Notice of Claim

(To Administrative Law Judge and to Employer)

Notice is hereby given that the injured worker, while in the employ of the employer, sustained injuries arising out of and in the course of his/her employment and died as a result of such work-related injury or illness in the manner described below.

His/her dependent makes claim for compensation benefits pursuant to Sec. 31-306 C.G.S.

Please TYPE or PRINT IN INK

DEPENDENT

Name _____

D.O.B. _____

Check, if a Minor ❑ *(under 18 yrs. of age)*

Relationship to deceased employee _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

DECEASED'S INJURY

Date of Injury _____

Date of Death _____

Town of Injury _____

Describe employee's Injury/Illness and its relationship to cause of death:

❑ Check, if an Occupational Disease or a Repetitive Trauma

❑ Check, if decedent had MORE THAN ONE Employer on Date of Injury

DECEASED EMPLOYEE

Name _____

D.O.B. *(required)* _____

DECEASED'S EMPLOYER

Employer _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

SIGNATURE OF DEPENDENT OR REPRESENTATIVE

Signature _____

Date _____

Print name & address below, if other than dependent:

Name _____

Name of Firm _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

This notice must be served upon the Administrative Law Judge and *Employer by personal presentation or by registered or certified mail. For the protection of both parties, the employer should note the date when this notice was received and the claimant should keep a copy of this notice with the date it was served.

* *Dependents of persons employed by the State of Connecticut must serve the employer by serving this notice upon the Commissioner of Administrative Services, 450 Columbus Boulevard, Hartford, CT 06103.*

* *Dependents of persons employed by a municipality must serve the employer by serving this notice upon the town clerk of the municipality in which the employee was employed.*

* *Dependents of persons employed by an employer who pursuant to statute has posted the location where this notice is to be filed have an obligation to file it at that location, using certified mail.*

WARNING: If an employer does not file a notice contesting liability (e.g. Form 43) for this claim OR begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date when this claim is received by personal delivery or by registered or certified mail, COMPENSABILITY SHALL BE PRESUMED and cannot thereafter be contested. If an employer chooses to begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date of receipt of this claim and still wishes to contest this claim, it must do so by filing a notice contesting liability for this claim within one year from receipt of this claim. [See Sec. 31-294c(b).]

There is a statute of limitations for filing a workers' compensation claim for death benefits. If death results within two years from the date of the accident or first manifestation of a symptom of the occupational disease, a claim may be made within the two year period, or within one year from the date of death, whichever is later. (Sec. 31-294c)

Directions for Completing the 30D Claim Form

1. In the box marked "**DEPENDENT**" – type or neatly print the name, date of birth, and address of the dependent who is filing the claim on behalf of the deceased worker. Remember to check the box, if the dependent is a minor (under the age of 18). **Identify the dependent's relationship to the deceased worker.**

2. In the box marked "**DECEASED EMPLOYEE**" – **type or neatly print the name of the deceased worker.** Also fill in the deceased worker's date of birth.

3. In the box marked "**DECEASED'S EMPLOYER**" – **type or neatly print the name of the deceased worker's employer.** (*This means the name of the organization the decedent worked for, not the boss or supervisor.)*

4. In the "**DECEASED's INJURY**" box – **type or neatly print the date of the deceased worker's injury, or the date of the 1st manifestation of their occupational illness.**

   Type the date of death and the town in which the injury actually took place.
   (Note: This will not necessarily be the same location as the employer's business address.)

   Briefly describe the employee's injury/illness and explain how it was related to their death.
   Also:
   Check the box if the employee died from an Occupational Disease, or a Repetitive Trauma.

   Check the box if the employee worked for MORE THAN ONE employer on the Date of Injury.

5. In the "**SIGNATURE OF DEPENDENT OR REPRESENTATIVE**" box – sign your name and fill in the date of your signature.

   If you are NOT the dependent for whom benefits are being claimed, then sign your name, and fill in the date of your signature. Then print your name and the name (if any) of your firm, as well as the address and telephone number.

Directions for Filing the 30D Claim Form

1. **Make two (2) extra copies of the completed 30D Form**.

2. **Send the original 30D to the deceased worker's employer** by Certified or Registered mail, requesting a return receipt. The claim may also be delivered in person if the employer acknowledges receipt of the claim in writing.

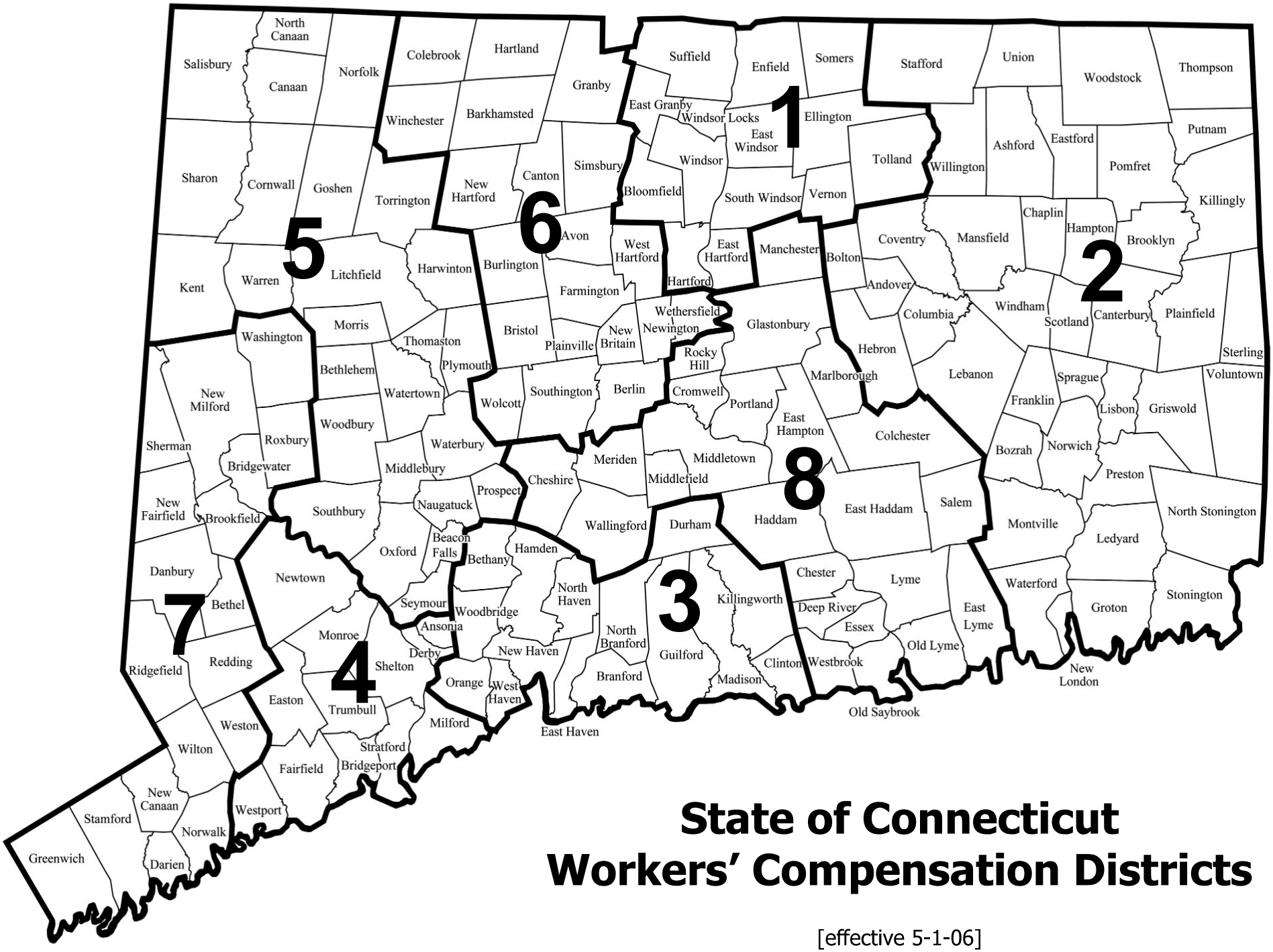
   A 30D Form filed on behalf of a dependent of a State employee must be delivered to the Commissioner of Administrative Services, 450 Columbus Boulevard, Hartford, CT 06103 and NOT to the particular office where the deceased worker was employed.

   A 30D Form filed on behalf of a dependent of a Municipal employee must be delivered to the town clerk of the municipality in which the deceased worker was employed.

   A 30D Form filed on behalf of a dependent of an employee (other than a State or municipal employee), who pursuant to statute has posted the location where claims for compensation are to be filed, must be filed at that location, by certified mail.

3. **Send a copy of the 30D to the appropriate Workers' Compensation Commission District Office** by Certified or Registered mail, requesting a return receipt, or deliver in person. The District Office is determined by the town in which the deceased employee was injured or in which they suffered their occupational illness. Refer to the Connecticut map provided with this form for the number and address of the appropriate Compensation District.

4. **Keep the remaining copy of the 30D for your own file**.



State of Connecticut
Workers' Compensation Districts

[effective 5-1-06]

Workers' Compensation Commission District Offices

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999 Asylum Avenue
Hartford, CT 06105

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Fax: (860) 566-6137

District 2 — Norwich

55 Main Street
Norwich, CT 06360

Phone: (860) 823-3900
Fax: (860) 823-1725

District 3 — New Haven

700 State Street
New Haven, CT 06511-6500

Phone: (203) 789-7512
Fax: (203) 789-7168

District 4 — Bridgeport

350 Fairfield Avenue
Bridgeport, CT 06604

Phone: (203) 382-5600
Fax: (203) 335-8760

District 5 — Waterbury

55 West Main Street
Waterbury, CT 06702

Phone: (203) 596-4207
Fax: (203) 805-6501

District 6 — New Britain

24 Washington Street
New Britain, CT 06051

Phone: (860) 827-7180
Fax: (860) 827-7913

District 7 — Stamford

111 High Ridge Road
Stamford, CT 06905

Phone: (203) 325-3881
Fax: (203) 967-7264

District 8 — Middletown

90 Court Street
Middletown, CT 06457

Phone: (860) 344-7453
Fax: (860) 344-7487