

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE				
1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number		
EMPLOYER				
4. Employer Business Name		ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1		10. Mailing Address 1		
6. Physical Address 2		11. Mailing Address 2		
7. City	8. State	9. Zip	12. City	13. State
14. Zip	15. Federal ID Number		16. U.C. Account Number	17. NAICS
INSURER / FILING OFFICE				
18. Insurer Name		21. Filing Office Name		
19. Insurer Federal ID Number		22. Mailing Address 1		
20. Type Insurer		23. Mailing Address 2 or Telephone Number		
Ins Co <input type="checkbox"/>	Self-Insurer <input type="checkbox"/>	Group Fund <input type="checkbox"/>	24. City	25. State
			26. Zip	27. Filing Office Federal ID Number
EMPLOYEE / WAGES				
28. First Name		32. Employee ID Number		
29. Middle Name		33. Type Employee ID Number		
30. Last Name		SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)		Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1		40. Gender	41. Date of Birth	
35. Mailing Address 2		Male <input type="checkbox"/>	42. Nbr of Dependents	
36. City	37. State	38. Zip	39. Phone	
43. Marital Status			44. Date Hired	
Unmarried (Single or Divorced or Widowed) <input type="checkbox"/>			Married <input type="checkbox"/>	
Separated <input type="checkbox"/>			Unknown <input type="checkbox"/>	
45. Occupation Description			46. Number of Days Worked Per Week	
47. Wages \$		49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>		50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>		
INJURY / TREATMENT				
51. Date of Injury	52. Time of Injury	53. Time Employee Began Work		54. Date Disability Began
		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>	a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	55. Date of Death
PLACE OF ACCIDENT, INJURY, OR EXPOSURE			61. Injury Occurred on Employer's Premises?	
56. Site Address			Yes <input type="checkbox"/> No <input type="checkbox"/>	
57. City			62. Date Employer Notified	
58. State			59. Zip	
60. County				
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)				
PROVIDE DESCRIPTION CODES to identify Nature of Injury, Part of Body that was affected, and Cause of Injury. (FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC)				
64. Nature of Injury Code		65. Part of Body Code		66. Cause of Injury Code
67. Initial Treatment		No Medical Treatment <input type="checkbox"/>		68. Name of Treatment Facility
First Aid By Employer <input type="checkbox"/>		Minor Clinic / Hospital <input type="checkbox"/>		69. Address
Emergency Room <input type="checkbox"/>		Hospitalized Overnight <input type="checkbox"/>		70. City
Hospitalized > 24 Hours <input type="checkbox"/>		Outpatient Treatment <input type="checkbox"/>		71. State
73. Name of Physician or Other Health Care Professional			74. Has Injured Returned to Work	
			Yes <input type="checkbox"/> No <input type="checkbox"/>	
			If so, 75. Date	
			76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
OTHER				
77. Date Prepared	78. Preparer's First Name	79. Last Name	80. Title	81. Preparer's Telephone Number

NATURE OF INJURY	PART OF BODY	CAUSE OF INJURY
01. No Physical Injury	10. Multiple Head Injury	01. Chemicals
02. Amputation	11. Skull	02. Hot Objects or Substances
03. Angina Pectoris	12. Brain	03. Temperature Extremes
04. Burn	13. Ear(s)	04. Fire or Flame
07. Concussion	14. Eye(s)	05. Steam or Hot Fluids
10. Contusion	15. Nose	06. Dust, Gases, Fumes or Vapors
13. Crushing	16. Teeth	07. Welding Operation
16. Dislocation	17. Mouth	08. Radiation
19. Electric Shock	18. Soft Tissue	09. Contact With, NOC.
22. Enucleation	19. Facial Bones	10. Machine or Machinery
25. Foreign Body	20. Multiple Neck Injury	11. Cold Objects or Substances
28. Fracture	21. Vertebrae	12. Object Handled
30. Freezing	22. Disc	13. Caught In, Under or Between, NOC.
31. Hearing Loss or Impairment	23. Spinal Cord	14. Abnormal Air Pressure
32. Heat Prostration	24. Larynx	15. Broken Glass
34. Hernia	25. Soft Tissue	16. Hand Tool, Utensil; Not Powered
36. Infection	26. Trachea	17. Object Being Lifted or Handled
37. Inflammation	27. Multiple Upper Extremities	18. Powered Hand Tool, Appliance
40. Laceration	31. Upper Arm	19. Caught, Puncture, Scrape, NOC.
41. Myocardial Infarction	32. Elbow	20. Collapsing Materials (Slides of Earth) Either Man Made or Natural
42. Poisoning - General	33. Lower Arm	25. From Different Level (Elevation) Off Wall, Catwalk, Bridge, Etc.
43. Puncture	34. Wrist	26. From Ladder or Scaffolding
46. Rupture	35. Hand	27. From Liquid or Grease Spills
47. Severance	36. Finger(s)	28. Into Openings Shafts, Excavations, Floor Openings, Etc.
49. Sprain or Tear	38. Shoulder(s)	29. On Same Level
52. Strain or Tear	39. Wrist (s) & Hand(s)	30. Slipped, Do Not Fall
53. Syncope	40. Multiple Trunk	31. Fall, Slip or Trip, NOC.
54. Asphyxiation	41. Upper Back Area	32. On Ice or Snow
55. Vascular	42. Lower Back Area	33. On Stairs
58. Vision Loss	43. Disc	40. Crash of Water Vehicle
59. All Other Specific Injuries, NOC	44. Chest	41. Crash of Rail Vehicle
60. Dust Disease, NOC	45. Sacrum and Coccyx	45. Collision or Sideswipe With Another Vehicle
61. Asbestosis	46. Pelvis	46. Collision with a Fixed Object Standing Vehicle or Stationary Object
62. Black Lung	47. Spinal Cord	47. Crash of Airplane
63. Byssinosis	48. Internal Organs	48. Vehicle Upset Overturned or Jackknifed
64. Silicosis	49. Heart	50. Motor Vehicle, NOC.
65. Respiratory Disorders	50. Multiple Lower Extremities	52. Continual Noise
66. Poisoning - Chemical, (Other Than Metals)	51. Hip	53. Twisting
67. Poisoning - Metal	52. Upper Leg	54. Jumping
68. Dermatitis	53. Knee	55. Holding or Carrying
69. Mental Disorder	54. Lower Leg	56. Lifting
70. Radiation	55. Ankle	57. Pushing or Pulling
71. All Other Occupational Disease Injury, NOC	56. Foot	58. Reaching
72. Loss of Hearing	57. Toes	59. Using Tool or Machinery
73. Contagious Disease	58. Big Toes	60. Strain or Injury By, NOC.
74. Cancer	60. Lungs	61. Welding or Throwing
75. AIDS	61. Abdomen Including Groin	65. Moving Part of Machine
76. VDT - Related Diseases	62. Buttocks	66. Object Being Lifted or Handled
77. Mental Stress	63. Lumbar & or Sacral Vertebrae	67. Sanding, Scraping, Cleaning Operation
78. Carpal Tunnel Syndrome	64. Artificial Appliance	68. Stationary Object
79. Hepatitis C	65. Insufficient Info to Properly Identify	69. Stepping on Sharp Object
80. All Other Cumulative Injury, NOC	66. No Physical Injury	70. Striking Against or Stepping On, NOC.
90. Multiple Physical Injuries Only	90. Multiple Body Parts	74. Fellow Worker; Patient
91. Multiple Injuries Including Both Physical & Psychological	91. Body Systems and Multiple Body	75. Falling or Flying Object
	99. Whole Body	76. Hand Tool or Machine in Use
		77. Motor Vehicle
		78. Moving Parts of Machine
		79. Object Being Lifted or Handled
		80. Object Handled By Others
		81. Struck or Injured, NOC.
		82. Absorption, Ingestion or Inhalation, NOC
		84. Electrical Current
		85. Animal or Insect
		86. Explosion or Flare Back
		87. Foreign Matter (Body) in Eye(s)
		88. Natural Disasters
		89. Person in Act of a Crime
		90. Other Than Physical Cause of Injury
		91. Mold
		94. Repetitive Motion Callous, Blister, Etc.
		95. Rubbed or Abraded, NOC.
		96. Terrorism
		97. Repetitive Motion Carpel Tunnel Syndrome
		98. Cumulative, NOC
		99. Other - Miscellaneous, NOC

INSTRUCTIONS FOR FILING WC FIRST REPORT OF INJURY

Employers should send a completed legible form to the insurance carrier or, if self-insured, to the designated office handling their workers' compensation claims. The insurance carrier or designated office should forward this First Report on to the Workers' Compensation Division, Department of Industrial Relations, Montgomery, Alabama 36131 within fifteen (15) days from the date of injury or date of notification to the employer for all injuries for which compensation is claimed or paid. This includes deaths, permanent disabilities or temporary disabilities exceeding three (3) days).

Block 1. A number assigned by the insured to identify a specific claim

Block 2. An identifier for a specific claim within a claim administrator's claims processing system.

Block 3. Case number from log maintained for OSHA

Block 4 - Block 14. Self Explanatory

Block 15. Employer Federal ID number

Block 16. Employer Unemployment Compensation Account Number

Block 17. NAICS Industry Codes http://dir.alabama.gov/docs/forms/wc_naics.pdf

Block 18. Carrier's name

Block 19. Carrier's FEIN

Block 20. A code representing the kind of entity providing financial responsibility for the claim, exp: (1)

Insurance Carrier (S) Self Insurer (G) Guarantee Fund/Group

Block 21 through Block 63. Self Explanatory

Block 64. Nature of Injury Codes http://dir.alabama.gov/docs/forms/wcio_nature_table.pdf

Block 65. Part of Body Codes http://dir.alabama.gov/docs/forms/wcio_part_table.pdf

Block 66. Cause of Injury Codes http://dir.alabama.gov/docs/forms/wcio_cause_table.pdf

Block 67 through Block 81. Self Explanatory

INSTRUCTIONS FOR FILING WC FROI RELEASE 2005

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