WORKER'S COMPENSATION
FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

Walker Professional Insurance

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex ☐ Male ☐ Female ☐ Unknown	Occupation / Job title	NCCI class code
Name (*last, first, middle*)		Marital status ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown	Date hired / State of hire	Employee status
Address (*number and street, city, state, ZIP code)*			Hrs / Day / Days / Wk / Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued
Telephone number (include area code)		Number of dependents	Wage $ Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ 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 ☐ Self Insurance
N/A		
Address of claims administrator (*number and street, city, state, ZIP code*)	☒ Insurance Carrier ☐ Third Party Admin.	Policy / Self-insured number
N/A		
Telephone number		Policy period From To
N/A		
Name of agent	Code number	
Walker Professional Insurance		

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp.	Time of occurrence ☐ AM ☐ 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? ☐ Yes ☐ 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 ☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor: Clinic / Hospital ☐ Emergency Care ☐ Hospitalized > 24 Hours ☐ Future Major Medical / Lost Time Anticipated
Name of witness	Telephone number	Date administrator notified		
Date prepared	Name of preparer	Title	Telephone number	