



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

State Form 34401 (R10 / 1-02)

FOR WORKER'S COMPENSATION BOARD USE ONLY

Jurisdiction	Jurisdiction claim number	Process date
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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	<input type="checkbox"/> Paid Day of Injury <input type="checkbox"/> Salary Continued			
Telephone number (include area)		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			OSHA log 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		Name of agent			Code number				
OCCURRENCE / TREATMENT INFORMATION									
Date of Inj./ Exp.	Time of occurrence <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Cannot be determined		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									
Hospital or offsite treatment (name and address)							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).