# WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

| EMPLOYER (NAME & ADDRESS INCL ZIP) | CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG CASE # | REPORT PURPOSE CODE |
|---|---|---|---|
| | JURISDICTION | JURISDICTION CLAIM NUMBER | |
| | INSURED REPORT NUMBER | | |
| | EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | | LOCATION # |
| INDUSTRY CODE / EMPLOYER FEIN | | | PHONE # |

## CARRIER/CLAIMS ADMINISTRATOR

| CARRIER (NAME, ADDRESS, & PHONE #) | POLICY PERIOD | CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) |
|---|---|---|
| LUBA<br>P.O. Box 98082<br>Baton Rouge, LA 70898<br>(225) 389-5822 | TO<br>CHECK IF APPROPRIATE<br>☐ SELF INSURANCE | LUBA<br>P.O. Box 98082<br>Baton Rouge, LA 70898<br>(225) 389-5822 |

| CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN |
|---|---|---|
| 20-3947910 | | 20-3947910 |

## EMPLOYEE/WAGE

| NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE |
|---|---|---|---|---|
| ADDRESS (INCL ZIP) | SEX<br>M MALE<br>F FEMALE<br>U UNKNOWN | MARITAL STATUS<br>U UNMARRIED SINGLE/DIVORCED<br>M MARRIED<br>S SEPARATED<br>K UNKNOWN | OCCUPATION/JOB TITLE<br>EMPLOYMENT STATUS | |
| PHONE | # OF DEPENDENTS | | NCCI CLASS CODE | |

| RATE PER: | ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER: | DAYS WORKED/WEEK | FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO<br>DID SALARY CONTINUE? ☐ YES ☐ NO |
|---|---|---|---|

## OCCURRENCE/TREATMENT

| TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN |
|---|---|---|---|---|---|

| CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED |
|---|---|---|
| DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE |

| DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED |
|---|---|
| SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED |

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

| DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO<br>WERE THEY USED? ☐ YES ☐ NO |
|---|---|---|

| PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS) | HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS) | INITIAL TREATMENT |
|---|---|---|
| | | 0 NO MEDICAL TREATMENT<br>1 MINOR: BY EMPLOYER<br>2 MINOR CLINIC/HOSP<br>3 EMERGENCY CARE<br>4 HOSPITALIZED > 24 HOURS<br>5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED |

## OTHER

WITNESSES (NAME & PHONE #)

| DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER |
|---|---|---|---|

 