Minnesota Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road North
St. Paul, MN 55155-4305
(651) 284-5030

First Report of Injury

See Instruction on Reverse Side
Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYY format.

FR01

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2.OSHA Case #		
3. DATE OF CLAIMED INJURY	4. Time of injury ☐ am ☐ pm	5. Time employee began work on date of injury ☐ am ☐ pm	
6. EMPLOYEE Name (last, first, middle)		7. Gender ☐M ☐F	8. Marital Status ☐ Married ☐ Unmarried
9. Home Address		10. Home Phone #	11. Date of birth
City State Zip code		12. Occupation	13. Regular department / 14. Date hired
15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week / 19. Employment Status ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer
20. Weekly value of: Meals	Lodging	2nd Income	21. Apprentice ☐ Yes ☐ No

22. **Tell us how the injury occurred and what the employee was doing before the incident (give details).** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of the body)?** *Example: chemical burn left hand, broken left leg, carpal tunnel syndrom in left wrist.*	24. **What tools, equipment, machines, objects or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No If no, indicate name and address of place of occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI
	28. Date employer notified of injury	29. Date employer notified of lost time
	30. Return to work date	31. Date of death

32. TREATING PHYSICIAN (name, address, and phone)	33. HOSPITAL/CLINIC (name and address) (if any)	34. Emergency Room Visit ☐ Yes ☐ No 35. Overnight in-patient ☐ Yes ☐ No

36. **EMPLOYER** Legal name		37. EMPLOYER DBA name (if different)
38. **Mailing** address		39. Employer FEIN / 40. Unemployment ID#
City State Zip Code		41. Employer's contact name and phone #
42. **Physical** address (if different)		43. Witness (name and phone)
City State Zip Code		44. NAICS code / 45. Date form completed
46. **INSURER** name		51. **CLAIMS ADMIN COMPANY** (CA) name (check one) ☐ Insurer ☐ TPA
47. Insured legal name		52. CA address
48. Policy # or self-insured certificate #		City State Zip Code
49. Insurer FEIN / 50. Date insurer received notice		53. CA FEIN / 54. Claim #

GENERAL INSTRUCTIONS TO THE EMPLOYER

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness requires medical care or lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the ten days may result in penalties. Self-insured employers have 14 days to file this form with the Department of Labor and Industry (Department). It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will forward a copy of this form** to the Department, if necessary.

If the claim involves death of serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-215-0170), or personal notice. The initial notice must be followed by the filing of this form within **seven** days of the occurrence.

Employers are required to complete this form. Each piece of information is needed to determine liability and entitlement to benefits. Failure to complete the form may result in delayed processing and possible penalties. You must file this form with your insurer, and give a copy to the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department's web site at www.doli.state.mn.us. Employees are not responsible for completing this form.

SEND REPORT TO INSURER IMMEDIATELY - DO NOT WAIT FOR DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS FOR COMPLETING THIS FORM

- Item 2: OSHA Case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 15-20: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage.
- Item 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of the body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost anytime from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and notify your insurer if the employee misses time due to this injury after the date.
- Item 39: Fill in your Federal Employment ID number (FEIN). For information on this number, see www.firstgov.gov and click on Employer ID Number under Business.
- Item 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code which are both assigned by the Department or Economic Security (651-296-6141).
- Item 46-54: Your insurer or claims administrator will complete this information.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR/SELF-INSURED EMPLOYER

The following data elements must be completed on this form prior to filing with the Department of Labor and Industry: employee's name and social security number; date and injury; and the names of the employer and insurer. If any of this information is missing, the First Report will be rejected and returned to you (per Minn. Stat. S 176.275). Providing the name of the third party administrator does not meet the statutory requirement to provide the name of the insurer. NOTE: If the claim does not involve lost time beyond the waiting period or potential PPD, the form does **NOT** need to be filed with the Department.

- Item 46: Fill in the name of the insurance company. If the employer is self-insured, indicate the name of the licensed or public self-insured company or group.
- Item 47-48: Fill in the legal name of the employer who purchased the policy from the insurer (name in Item 46) and the policy number. If the employer is licensed to self-insure, fill in the certificate number.
- Item 49: Fill in the insurer's Federal Employment ID number (FEIN) number.
- Item 51: Fill in the name and address of the company administering the claim (either the insurer or third party administrator). Be sure to mark either the "Insurer" or "TPA" box.
- Item 53-54: Fill in the claims administrator's FEIN and claim number.

This material can be made available in different forms, such as large print, Braille or on tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.