Insperity
HR that Makes a Difference™

First Report of Injury
Workers' Compensation Notification

Completion Instructions:

- Use this form to report a work-related injury.
- Complete form and email to reportaclaim@insperity.com or fax to Sedgwick at 501-221-5991.

Note: Work-related injuries must be reported within 24 hours of occurrence or treatment.

Account # **4039**	Client Number (Location Code)	Filing State

Mandatory for Minnesota Employees Only: Print this copy of the *Minnesota Worker's Compensation System Employee Information Sheet.*

Client Information

Client Company Name		
Location Address		
City	State	Zip Code
Preparer's Name	Title	Phone Number

Injured Employee's Information

Date of Injury (mm/dd/yyyy)	Employee Name	Last 4 Digits of Social Security Number	Insperity Employee ID Number

Current Mailing Address		
City	State	Zip Code

Home Phone	Date of Birth	☐ Male ☐ Female	Marital Status (If Married, Spouse's Name)
Number of Dependents	Number Under Age 18	Employee's Language	

Injured Employee's Work Information

Employee's Regular Occupation		Department
Department at Time of Injury (CA, TX Only)		Was Employee Performing Regular Job Duties at Time of Incident? ☐ Yes ☐ No
Is Employee Partner, Officer or Owner? ☐ Partner ☐ Officer ☐ Owner	Hire State	Does Employee Receive ADA Accommodations? ☐ Yes ☐ No

Employment Status	Job End Date (If Employee is Seasonal or Temp)	Date in Current Job

Accident/Incident Information

Does Employee Have Group Health? ☐ Yes ☐ No	Time of Accident a.m. p.m.	Date/Time Reported to Employer Date Time

Reported to Whom	Supervisor's Name
Shift Begin/End Time From To	Date Employee Received Claim Form? (CA Only)

Incident Address	Employer's Premises? ☐ Yes ☐ No

City	State	County	ZIP Code

Description of Accident/Incident (Include what the employee was doing, Work Process, Cause, Injury and Body Part)

Questionable? (If Yes, Contact Name) ☐ Yes ☐ No	Name	Phone Number

10303 #

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Accident/Incident Information (Continued)

Is Employee Permanently Disabled Because of Incident? Yes ☐ ☐ No	Signs of Drug/Alcohol Use? ☐ Yes ☐ No	Fatality? (If Yes, Date) ☐ Yes ☐ No Date	
Number of Days Expected to Miss	Last Date/Time Worked Date Time	First Day Off	Was Employee's Salary Continued? ☐ Yes ☐ No

Actual OR **Expected** Return to Work Date	Is There a Previous Claim/Injury? (If Yes, Claim Status and Body Part Affected) ☐ Yes ☐ No

Safety Equipment Provided? ☐ Yes ☐ No	Was it Used? ☐ Yes ☐ No	Unsafe Act? (If Yes, Describe) ☐ Yes ☐ No ____
Machine Part Involved? (If Yes, Describe) ☐ Yes ☐ No		
Machine Part Defective? (If Yes, Describe) ☐ Yes ☐No		

Third Party Responsible for Incident? (If Yes, Name) ☐ Yes ☐ No	Name	Phone Number
Address		
City	State	ZIP Code

Witness? (If Yes, Name) ☐ Yes ☐ No	Name	Phone Number
Address		
City	State	ZIP Code

Name of Contact Regarding Additional Loss Information		Phone Number
Address		
City	State	ZIP Code

First Aid Given on Site? ☐ Yes ☐ No	Medical Treatment Received (Describe)

Name of Physician/Health Care Provider		Phone Number
Address		
City	State	ZIP Code

Hospitalized? (If Yes, Date) ☐ Yes ☐ No Date	Name of Hospital	Hospital Phone Number
Address		
City	State	ZIP Code

Treated Outpatient? ☐ Yes ☐ No	Emergency Treatment, Ambulance Services? ☐ Yes ☐ No
Comments	

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