



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
 DIVISION OF WORKERS' COMPENSATION
REPORT OF INJURY

P.O. BOX 58
 JEFFERSON CITY, MO 65102-0058

(To complete form, see attached instructions)

GENERAL	EMPLOYER (NAME, ADDRESS, INCL ZIP CODE)		CARRIER ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE			
	JURISDICTION		JURISDICTION CLAIM NUMBER					
	INSURED REPORT NUMBER							
	EMPLOYERS LOCATION ADDRESS (IF DIFFERENT)			LOCATION #	PHONE #			
SIC CODE		EMPLOYER FEIN						
CARRIER CLAIMS ADMIN	CARRIER (NAME, ADDRESS & PHONE NO.)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)				
			to					
	CHECK IF APPROPRIATE		<input type="checkbox"/> SELF INSURANCE					
	CARRIER FEIN	INSURANCE POLICY NUMBER			ADMINISTRATOR FEIN			
AGENT NAME & CODE NUMBER								
EMPLOYEE	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY #	DATE HIRED	STATE OF HIRE		
	ADDRESS (INCLUDE ZIP)		SEX	MARITAL STATUS		OCCUPATION JOB TITLE		
			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> UNMARRIED <input type="checkbox"/> SINGLE DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		EMPLOYMENT STATUS		
	PHONE #	# OF DEPENDENTS				NCCI CLASS CODE		
WAGE	RATE	PER	<input type="checkbox"/> DAY <input type="checkbox"/> WEEK	<input type="checkbox"/> MONTH <input type="checkbox"/> OTHER	# OF DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
					DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
OCCURRENCE	TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE	<input type="checkbox"/> AM <input type="checkbox"/> 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?		<input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE	
	ZIP CODE OF THE LOCATION WHERE THE 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 TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
					WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
TREAT- MENT	PHYSICIAN HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)			INITIAL TREATMENT		
						<input type="checkbox"/> 0 - NO MEDICAL TREATMENT <input type="checkbox"/> 1 - MINOR: BY EMPLOYER <input type="checkbox"/> 2 - MINOR CLINIC HOSPITAL <input type="checkbox"/> 3 - EMERGENCY CASE <input type="checkbox"/> 4 - HOSPITALIZED > 24 HOURS <input type="checkbox"/> 5 - FUTURE MAJ. MED. LOST TIME ANTICIPATED		
OTHERS	WITNESS (NAME & PHONE #)							
	DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER		