MSD OF MARTINSVILLE

P.O. Box 1416 | 389 E. Jackson Street
Martinsville, Indiana 46151
Ph 765-342-6641 | Fax 765-342-6877

ALL INJURIES MUST BE IMMEDIATELY REPORTED

Workers Compensation Claim Reporting Worksheet

Please complete this form and email it to brittany.davis@msdmartinsville.org.

1. General Information

Submitter Name: _____ Date of injury: _____

Submitter Title: _____ Submitter Phone: _____

Contact person for claim: _____

Contact phone: _____ Contact email: _____

2. Injured Employee Information

First Name | M | Last Name | Social Security Number

Email | Phone #

Mailing Address

Gender | Marital Status | No. of Dependents

Hire Date | Job Title | Emp. Status

Supervisor Name | Phone # | Email

3. Incident Information

Building where incident occurred | Room # or other specific location at building

Time of injury | Time shift started | Did injury result in death?

Did injured employee lose hours because of incident?

If yes, answer below questions:		*If no, skip to next section*	
Date last worked:		# of days missed:	
First day off work:		Date returned:	

Restrictions: _____ Restricted hours? _____

Other restriction information: _____

Date injury reported to supervisor | Supervisor Name | Supervisor Phone #

Witness #1 Name | Witness #1 Phone #

Witness #2 Name | Witness #2 Phone #

Type of injury: _____

Body part(s) injured (specific): _____

Check applicable: _____
Right Left Both

What caused injury: _____

What was activity employee engaged in when injury occurred:

Equipment involved: _____

Safeguards in place? _____
Yes No

4. Treatment Information

Type of Initial Treatment
Check one

_____	No Treatment	_____	Building Nurse
_____	Everside Health Clinic	_____	Other Clinic
_____	ER (self transport)	_____	ER (ambulance)

Initial Treatment Facility Information

Facility Name

Facility Address

Facility Phone # Physician/Provider Name

Follow-up treatment: _____

Signature of Injured Employee or Preparer Date

All injuries must be reported immediately.

Please give signed form to supervisor or building administrator to submit to the Business Office.

For Business Office use only	
Received: / /20	Submitted: / /20
Serial #:	300A: Yes No
BCode:	ECode:

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.

2. Enter all dates in MM/DD/YY format.

3. Please return completed form electronically by an approved EDI process.

4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME AND CODE NUMBER: Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (*e.g. Acetylene cutting torch, metal plate, etc.*).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME / TELEPHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc.*)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised deigned by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc.*).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: (*FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK*).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (*e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall*).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc.*)

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (*Return to Work Date)***:** Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc.*)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).

Reset Form

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

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	Occupation / Job title	NCCI class code
		☐ Male ☐ Female ☐ Unknown		9101

Name (*last, first, middle*)	Marital status	Date hired	State of hire	Employee status
	☐ Unmarried ☐ Married ☐ Separated ☐ Unknown			

Address (*number and street, city, state, ZIP code)*	Hrs / Day	Days / Wk	Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued

Telephone number (include area	Number of dependents	Wage $	Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number
Metropolitan School District of Martinsville	35-6002624	611110	

Address of employer (*number and street, city, state, ZIP code*)	Location number	Employer's location address (*if different)*
389 E Jackson Street Martinsville, Indiana 46151	EA94986	
	Telephone number: 765-342-6641	
	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
Eastern Alliance Insurance Company		☒ Self Insurance

Address of claims administrator (*number and street, city, state, ZIP code*)		Policy / Self-insured number
PO Box 83777	☒ Insurance Carrier ☐ Third Party Admin.	010000602219
Telephone number: 855-533-3444		Policy period: From 01/31/2023 To 01/31/2024

Name of agent	Code number
First Insurance Group, Inc.	518

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp.	Time of occurrence ☐ AM ☐ PM ☐ 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? ☐ Yes ☐ 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
- ☐ No Medical Treatment
- ☐ Minor: By Employer
- ☐ Minor: Clinic / Hospital
- ☐ Emergency Care
- ☐ Hospitalized > 24 Hours
- ☐ 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).