Fire Department Name _____ FDID _____

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCLUDING ZIP)
State Of Louisiana
Office of State Fire Marshal
8181 Independence Blvd
Baton Rouge, LA 70806

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION # (IF AVAILABLE)

INDUSTRY CODE | EMPLOYER FEIN: 72-0724657 | PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE #)
LWCC
P.O. Box 98054
Baton Rouge, LA 70898

POLICY PERIOD TO

CHECK IF APPROPRIATE: SELF-INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE #)

CARRIER FEIN | POLICY/SELF-INSURED NUMBER: 134893 | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SEC. # (IF THERE IS ONE) | DATE HIRED | STATE OF HIRE: LOUISIANA

ADDRESS (INCLUDING ZIP)

SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN

MARITAL STATUS: ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE # | # OF DEPENDENTS | NCCI CLASS CODE

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK: ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE: ☐ AM ☐ PM ☐ CANNOT BE DETERMINED | 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 RETURNED TO WORK | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO | WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH-CARE PROVIDER (NAME & ADDRESS) | HOSPITAL OR OFF-SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT:
☐ NO MEDICAL TREATMENT
☐ MINOR: BY EMPLOYER
☐ MINOR: CLINIC/HOSPITAL
☐ EMERGENCY CARE
☐ HOSPITALIZED > 24 HOURS
☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

WITNESS(ES) NAME(S) & PHONE #(S)

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