



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					
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #	
	SIC CODE	EMPLOYER FEIN	PHONE #			
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 SINGLE DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		EMPLOYMENT STATUS
	PHONE #	# OF DEPENDENTS		NCCI CLASS CODE		
WAGE	RATE		# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	PER <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER			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
	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