MW	CC -	WOR	KE	ERS' COMP	EN	ISATION - F	FIF	S	T REP	ORT OF	INJURY	OF	RILL	NESS	5		
EMPLOYER (NAME & ADDRESS INCL ZIP)					CA	CARRIER/ADMINISTRATOR CLAIM NUMBER								REPORT PURPOSE CODE			
					JU	JURISDICTION JURISDICTION CLAIM NU						1BER	<u> </u>				
					INSURED REPORT NUMBER												
						EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)								LOCATION #			
SIC CODE EMPLOYER FEIN						EMPLOTER'S LOCATION ADDRESS (IF DIFFERENT)							PHONE #				
CARRIER/CLAI				ATOR													
CARRIER (NAME, ADDRESS & PHONE NO)					PC	POLICY PERIOD				CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)							
										-							
						SELF INSURANCE											
CARRIER FEIN POLICY/SELF-INSURED NUM						jek						ADMINISTRATOR FEIN					
AGENT NAME & CODE I	NUMBER	ł															
EMPLOYEE/WAGE NAME (LAST, FIRST, MIDDLE)						ATE OF BIRTH	SOCIAL SECU			RITY NUMBEF	DATE HIRED		STATE OF HIRE				
ADDRESS (INCL ZIP)					SE	٦		MA	ARITAL STA		(1.1)	000	CUPATIC	N/JOB T	ITLE		
					$\vdash$	MALE (M) FEMALE (F)		-	UNMARRIE	ED/SINGLE/DI∖ (M)	ORCED (U)	EMF	PLOYME	NT STAT	US		
						UNKNOWN (U)			SEPARAT	<b>、</b> ,							
PHONE					# O	OF DEPENDENTS		-	UNKNOW	~ /		NCCI CLASS CODE					
RATE PER: DAY MONTH				MONTH	#D/	AYS WORKED WEE				FULL PAY FOR DAY OF INJUR			Y? YES			NO	
		WEEK	,	OTHER:			_	_		DID SALARY	CONTINUE?				YES	NO	
OCCURRENCE/T	REATI		DA'	TE OF INJURY/ILLNE	ESS	TIME OF		АМ	LAST WOF	RK DATE	DATE EMPLO	YER N	OTIFIED	DATE DI	SABILITY BI	EGAN	
TIME EMPLOYEE BEGAN WORK	F	PM				TIME OF OCCURRENCE		PM									
CONTACT NAME/PHONE I	NUMBER					TYPE OF INJURY/IL	LNE	ESS	J		PART OF BOI	DY AFI	FECTED				
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES'					?	TYPE OF INJURY/IL	LLNESS CODE				FFECTED CODE						
	UNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED																
						c	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLI OR ILLNESS EXPOSURE OCCURRED						EE WAS	USING W	HEN ACCIL	ENI	
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDE XPOSURE OCCURRED					ENT (		WORK PROCESS THE EMPLOYEE WAS ENGAGED EXPOSURE OCCURRED					D IN V	VHEN AC	CIDENT C	R ILLNESS	}	
HOW INJURY OR ILLNE DIRECTLY INJURED TH							ΉE	SEC	UENCE OF	EVENTS ANI	D INCLUDE AN	NY OB			TANCES		
DATE RETURN(ED) TO WORK IF FATAL, GIVE DATE OF DEA						TH WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?									YES YES	NO NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)						HOSPITAL (NAME & ADDRESS)								INITIAL TREATMENT NO MEDICAL TREATMENT (0)			
																. /	
															INIC/HOSF NCY CARE		
WITNESSES (NAME & PH	HONE #)					•							HOSE	PITALIZE	) > 24 HRS	6 (4)	
DATE ADMINISTRATOR I	NOTIFIED		PRE	EPARED	PR	EPARER'S NAME &	<u>4 TIT</u>	TLE						TIME AN	MEDICAL TICIPATED	(5)	
															-		