

### First Report of Injury

See Instructions on Reverse Side, Type or Print.  
 All dates must be entered in MM/DD/YY format

1. OSHA Case #
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<b>EMPLOYEE</b> 2. Name (last, first, middle)		3. EMPLOYEE SOCIAL SECURITY NO:	
4. Home address (include county and zip)		5. DATE OF CLAIMED INJURY:	
Rice County		Do Not Use this Space	
8. Occupation:		6. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single
11. Regular Dept:		9. Date of Birth: ___/___/___	10. Date of Hired: ___/___/___
<b>WAGE INFORMATION</b>		15. Rate per hour:	
14. Average wage/week		16. Hours per day:	
17. Days per week:	18. What is the weekly value of MEALS: _____ LODGING: \$_____ 2ND INCOME: \$_____		
19. Employment Status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer (attach 26 week wage statement for part-time or irregularly scheduled employee)			
<b>OCCURRENCE</b> 20. PLACE (include dept. & full address)		21. Date of first day of any lost time: ___/___/___	22. Date employer notified of injury: ___/___/___
One North College St. Carleton College Northfield, MN 55057		23. Return to work date: ___/___/___	24. Date employer notified of lost time: ___/___/___
On employer's premises? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Date of death: ___/___/___	26. Time of day of injury: ___ AM ___ PM
27. DESCRIBE NATURE OF INJURY OR ILLNESS IN DETAIL, BE SPECIFIC (include part(s) of body affected, e.g. amputation of right index finger at 2nd joint, fractured arm, lead poisoning)			
28. DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURRED WITH DETAILS OF HOW EVENT OCCURRED (include name of other individuals involved, tools, machinery, objects, vapors, chemicals, radiation, unnatural motions of employee)			
29. PHYSICIAN (full name, title, address and phone number)		30. HOSPITAL/CLINIC (name and address)	
		31. Witness and phone number:	
<b>EMPLOYER</b> 32. Legal name & mailing address incl. zip		33. Date form completed: ___/___/___	34. Employ ID No.:
Carleton College, One North College St., Northfield, MN 55057		35. SIC code	
36. Print supervisor's name and phone number:		37. Employer's Representative, print full name, title and phone number: Samantha Malecha 507-646-7142	
<b>SEND REPORT IMMEDIATELY - DO NOT WAIT FOR DOCTOR'S REPORT</b>		CONTAINS ALL ITEMS REQUIRED BY OSHA FORM 101	
EMPLOYER STOP HERE - DO NOT USE THIS SPACE		T OCC	
<b>INSURANCE</b> 38. CARRIER (name, address & phone no.)		39. Insurer ID No.:	40. ADJUSTER Name & Address:
		41. Insurance Class Code:	
42. CARRIER CLAIM NUMBER		43. DATE insurer received notice:	44. Adjuster ID No:

## IMPORTANT NOTICE

The filing of this report is not an admission of liability. It should be filed with your insurance carrier whenever anyone believes a work-related injury or illness has occurred. The prompt filing of this report with your insurance carrier and the Department of Labor and Industry is required by law. Failure to report the claim within ten days may subject you to penalties. (If you are self-insured, your time limit is 14 days.) You should file this report immediately with your insurer. This will allow your insurer as much time as possible to investigate the claim. Even if the claim is questionable, it is important that you report it promptly. If you question the claim, attach any additional information to this report. Each case should also be recorded on your OSHA 200 log, if necessary.

## GENERAL INSTRUCTIONS TO THE EMPLOYER

Death or serious injury arising from employment must be reported to the Department of Labor and Industry within 48 hours of the occurrence. You may initially report by telephone (612-297-1272), telegraph, facsimile (612-215-0170), or personal notice within 48 hours, but that notice must be followed by the filing of this report with your insurer within seven days of the occurrence. If a reported injury subsequently results in death, a report of the death must be made to the Department and your insurer within 48 hours of when you are notified of the death.

Whenever you become aware of any work-related injury or illness that required medical care or lost time from work, you must report the injury to your insurer as soon as possible. If the employee cannot work for a period of more than three days, the workers' compensation claim must be made on this form and reported to your insurer within ten days. However, your insurer may require that you file it sooner. Your insurer will forward the form to the Department of Labor and Industry if necessary.

Please print or type. It is absolutely essential that you fill in all the information you can. Each piece of information is needed to determine liability and entitlement to benefits. Failure to complete the form may result in delayed processing and possibly penalties. Provide copies to your insurance carrier and your injured worker. If the claim results in the employee's inability to work for a period of more than three days, send a copy of this report to the employee's local union office.

## SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON FILLING OUT THE FIRST REPORT OF INJURY FORM

- ◆ Item 1: OSHA Case #. Fill in the case number from the OSHA 200 log.
- ◆ Items 14-19: Be sure to fill in all the wage information. If the claimant does not work a regular work week, attach a 26 week wage statement and your insurer will calculate the appropriate average weekly wage.
- ◆ Item 21: Fill in the first day the employee lost any time from work, even if you paid the employee for the full day.
- ◆ Item 22: Be sure to fill in the date you first become aware of the injury or illness. This is used to determine whether the form is filed late. You have ten days from the date you become aware of this injury to report this to your carrier.
- ◆ Item 23: If the employee has not returned to work by the time you are filing this form, leave the box blank. If the employee has returned to work and you indicate this on the form, be sure to notify your insurer immediately if the injured employee misses time later due to this injury.
- ◆ Item 27: Be as specific as possible in describing the injury. Indicate (1) the nature of the injury: cut, sprain, burn, etc. and (2) parts of the body injured: back, arm, hand, etc.
- ◆ Item 28: Be as specific as possible in describing the event. Indicate (1) name of object or substance involved: machine, tool, chemical, etc. and (2) type of accident: fall, struck by, etc.
- ◆ Items 34 and 35: Unemployment ID number and SIC code. These numbers are assigned by the Department of Economic Security. Call them at 612-296-6141 if you don't have a SIC or unemployment insurance number.
- ◆ Do not fill in items 38-44. Your insurer will add this information.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.