

EMPLOYER'S FIRST REPORT OF INJURY

Completion Tips

STATE OF ALABAMA EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE FAX COMPLETED FORM TO (205) 991-7978					
CLAIM REFERENCE					
FEDERAL TAX ID NUMBER (REQUIRED): 63-1111111			INSURED POLICY NUMBER: 600-2015-12345-00		
EMPLOYER					
Employer Business Name: Blooming Tulips Physical Address 1: 100 Bloomington Trail Physical Address 2: City: Employertown State: AL Zip: 12345			ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS: Mailing Address 1: PO Box 1234 Mailing Address 2: City: Employertown State: AL Zip: 12345		
INSURER / FILING OFFICE					
Insurer Name: <i>Sheffield Risk Management</i> Mailing Address: <i>1800 Corporate Drive</i> City: <i>Birmingham</i> State: <i>AL</i> Zip: <i>35242</i>			Filing Office Phone Number: <i>(205) 991-7552</i> Filing Office Fax Number: <i>(205) 991-7978</i>		
EMPLOYEE / WAGES					
First Name: Summer Middle Name: Bree Last Name: Sunshine Last Name Suffix:			EMPLOYEE SSN: 111-22-3333 DATE OF BIRTH: 09/01/1990		
Mailing Address 1: 1234 Dirt Drive Mailing Address 2: City: Employertown State: AL Zip: 12345 39. Phone: 205/###-####			Gender: Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>	Date of Hire: 4/15/14	
Marital Status: Unmarried (Single/Divorced/Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input checked="" type="checkbox"/>			Nbr of Dependents: 0		
Occupation Description: Fertilizer Specialist			# of Days Worked Per Week: 5		
Wages: \$546.00 # of Hours Worked Per Week: 37.50 Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>			Received Full Pay For Day of Injury? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Did Salary Continue After Incident? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
INJURY / TREATMENT					
DATE OF INJURY: 1/14/14	Time of Injury: 12:59 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	Time Employee Began Work: 8:00 a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>	Date Disability Began: 1/15/14	Date of Death:	
PLACE OF ACCIDENT, INJURY, OR EXPOSURE: Site Address: 100 Bloomington Trail City: Employertown State: AL Zip: 12345 County: Sinclair			Injury Occurred on Employer's Premises? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Date Employer Notified: 1/14/14		
DESCRIBE IN DETAIL WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT, HOW THE INJURY OCCURRED AND BODY PARTS AFFECTED: Summer was mixing fertilizer, preparing to spray plants when some got into her right eye, causing watering and redness.					
Initial Treatment: No Medical Treatment <input type="checkbox"/> First Aid By Employer <input type="checkbox"/> Minor Clinic <input checked="" type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/>					
Name of Treatment Facility/Physician: Urgency Clinic Address: 1 Medical Urgency Drive City: Ourtown State: AL Zip: 12346					
Has Injured Returned to Work? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			Date Injured Returned to Work: 1/16/14		
OTHER					
Date Prepared: 1/16/14	Preparer's First & Last Name: Title: Ray Bloomington, Owner		Preparer's Phone: 205/###-#### Preparer's Fax: 205/###-#### Preparer's E-mail: Bloomingtulips@internet.com		

Mandatory Employer's Federal Tax I.D. Number

Your member number which may begin with 600-

Provide FULL name & last known address

Mandatory

Where did accident occur?

Date doctor took employee out of work

Has Employee returned back to work? Date?

Provide complete details regarding how accident occurred including specific body parts.

Thorough form completion by a supervisor, manager, or H.R. person.

Please provide email address if possible.

THE EMPLOYER'S FIRST REPORT OF INJURY FORM SHOULD BE COMPLETED AS SOON AS POSSIBLE. THERE ARE 3 DIFFERENT WAYS TO SUBMIT THIS FORM...

- FAX**
(205) 991-7978
- EMAIL**
NEWCLAIM@SHEFFIELDRISK.COM
- MAIL**
SHEFFIELD RISK MANAGEMENT
1800 CORPORATE DRIVE
BIRMINGHAM, AL 35242