### ALL COPIES OF THIS FIRST REPORT MUST BE TYPED OR PRINTED

Department of Labor

Office of Workers' Compensation (OWC)

4425 N. Market Street Wilmington, DE 19802

Telephone 302-761-8200

# STATE OF DELAWARE FIRST REPORT

OF OCCUPATIONAL INJURY OR DISEASE

**OWC** Case File No.

## ALL INFORMATION IS REQUIRED, unless not applicable where "if applicable" is noted.

1. EMPLOYEE: FIRST								2. EMPLOYEE SOCIAL SECURITY NO.				
3. ADDRESS - INCLUDE COUNTY AND ZIP CODE							4.  MALE   5. EMPLOYEE PHONE NUMBER (INCLUDING AREA CODE)  FEMALE					
6. DATE OF BIRTH	7. AGE 8. WAGE						9. WEEKLY HOURS WORKED					
10. OCCUPATION (REGULAR	MENT OR DIVISIO	SION REGULARLY EMPLOYED 12. HOW LONG				OW LONG	EMPLOYED					
13. EMPLOYER:								14. PERSON MAKING OUT THIS REPORT				
15. ADDRESS - INCLUDE COUNTY AND ZIP CODE							16. EMPLOYER PHONE # (INCLUDE AREA CODE)					
							NATURE OF BUSINESS - TYPE OF MFG., TRADE, STRUCTION, SERVICE, ETC.					
19. WORKERS' COMPENSATION INSURANCE CARRIER  20. WORKERS' COMP. INS. CARRIER PHONE #, (INCLUDING AREA CODE)												
21. WORKERS' COMP. INSURANCE CARRIER ADDRESS							22. POLICY NUMBER / CARRIER CASE NUMBER:					
23. THIRD PARTY ADMINISTRATOR (TPA), IF APPLICABLE  24. TPA ADDRESS - INCLUDE CITY STATE AND ZIP CODE												
DATES:					28. IF EMPLOYEE BACK TO WORK GIVE DATE 29. AT SAME WAGE?							
25. DATE OF REPORT / / / / / / / / / / / / / / / / / / /			27. NORMAL STARTING TIME  AM PM				WORK GIVE BATE  /  /  YES \ NO \					
30. IF FATAL INJURY, GIVE DATE OF DEATH /		31. DATE EMPLOYER KNEW OF INJUI			32. 1	32. DATE DISABILITY BEGAN  / 33. LA			33. LAST	FULL DAY PAID-DATE / /		
INJURY OR DISEASE: 34. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.												
35. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.												
OCCURRENCE: 36. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE USED WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.												
37. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, E.G. LIFTING A PATIENT.												
38. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED.												
39. NAME OF PHYSICIAN (IF APPLICABLE)				40. PHYSICIAN	40. PHYSICIAN'S ADDRESS							
41. HOSPITAL (IF APPLICABLE)  42. HOSPITAL ADDRESS												

## **DISTRIBUTION OF THIS REPORT (1 original and 3 copies)**

- 1. ORIGINAL MUST BE SENT IMMEDIATELY TO THE WORKERS' COMPENSATION INSURANCE CARRIER.
- 2. COPY TO THE OFFICE OF WORKERS' COMPENSATION (use the address at the top left of this form)
- 3. EMPLOYER'S COPY RETAIN AS RECORD
- 4. EMPLOYEE'S COPY

# **WORKERS' COMPENSATION**

# **IMPORTANT THINGS TO DO IN CASE OF INJURY**

### THE EMPLOYER SHOULD:

- 1. Provide all necessary medical, surgical and hospital treatment from the date of accident.
- 2. Every employer shall keep a record of all injuries received by employees and make a report within 10 days thereof in writing to the Office of Workers' Compensation.
- 3. Ascertain the average weekly wages of the employee and provide compensation in accordance with the provisions of the law, for disability *beyond the third day* after the accident. All agreements as to compensation must be submitted to the Office of Workers' Compensation for approval.

## THE EMPLOYEE SHOULD:

- 1. Immediately notify the employer in writing of accidental injury or occupational disease and request medical services. Failure to give notice or to accept medical services may deprive the employee of the right to compensation.
- 2. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf.
- 3. In case of failure to reach an agreement with the employer in regard to compensation under the law, file application with the Industrial Accident Board for a hearing on the matters at issue within two years of the date of accidental injury or one year of knowledge of the diagnosis of an occupational disease or an ionizing radiation injury. All forms can be obtained from the Office of Workers' Compensation.