WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS

Alabama
Employee's County:
Return to work (Y/N):
At what Occupation:
At what Wage $:
Return to work wage is per (Day, Week or Month):
Employer's ID (U.C. Account) Number:
What Specific Product(s) does the business produce:

Alaska – No Additional State Questions

Arizona
Last Day of Work after injury:
Number of Days per Week Company usually Works:
Department Number:
If Validity of Claim is Doubted, state Reason:
Has injured been employed for more than 12 months (Y/N):
Was employee on overtime when injured (Y/N):

Arkansas – No Additional State Questions

California
State Unemployment Insurance Account Number:
Date employee was provided Employee Claim Form:
Has your employee pre-designated a primary treating physician (Y/N):
If Yes, Primary Treating Physician's…
First Name: Last Name: Street Address:
City: State: Zip: Phone:
If No, did your employee require medical treatment (Y/N):
If Yes, Treating Physicians…
First Name: Last Name: Phone:
If No, and employee requires medical treatment in the future, you can go to our website WWW.MYWCOMPINFO.COM to find a provider in the Medical Provider Network.

Colorado
Employer Federal ID Number:
Does Employer have a Salary Continuation Program (Y/N)
If "Yes" is this program registered with the state (Y/N)

Connecticut – No Additional State Questions

Delaware
Employer's UC Reporting Number:
Employees County:
Returned to work (Y/N): If Yes, at same wage (Y/N):

District of Columbia
Employer ID Number:
Returned to work (Y/N):
If Yes, at what Time: AM/PM
At what Wage $: Per (Day, Week or Month):
Was injured hired in DC (Y/N):
Was employee in his/her regular occupation when injured (Y/N):
Was injured given Form #7 DCWC (Y/N):
Piece or Time Worker (piece, time or blank):

Florida – No Additional State Questions

Georgia
Wage Rate at time of injury $: Per:
First Date employee failed to work a full day:
Did employee work the next day (Y/N):
Return to work Wage $:
Return to work wage is per (Day, Week or Month):

Hawaii
Was employee furnished meals or lodging (Y/N):

Idaho – No Additional State Questions

Illinois
Has the injured worker signed a medical authorization (Y/N):
If yes, inform them to please fax the signed medical authorization to the med auth customer service specialist at 1-877-786-5567.

Indiana – No Additional State Questions

Iowa – No Additional State Questions

Kansas
SIC Code:
Was worker admitted to hospital (Y/N):
If Yes, Date of Admission:
Was worker treated in emergency room only (Y/N):
Returned to work (Y/N):
If employee has returned to work, was return to light duty (Y/N):
Is further medical aid needed (Y/N):
Is compensation now being paid (Y/N):
If Yes, Date of first Initial Payment:
Fatal (Y/N):
If Yes, Name and Address of Dependents:

Kentucky – No Additional State Questions

Louisiana
Employer's Federal ID Number:
Employer's Unemployment Insurance Reporting Number:
Returned to work (Y/N):
If Yes, at same wage (Y/N):
Last Full Day Paid:
If occupational disease, Date of Initial Diagnosis:
Parish (county) where injury occurred:

Maine
Employer's State Unemployment Insurance Account Number (UIAN):
Federal Employer Insurance Number (FEIN):

Maryland – No Additional State Questions

Massachusetts
Federal ID Number:
Returned to work (Y/N):
Did employee return to his/her regular occupation (Y/N):
Describe nature of business or article manufactured (S=Service, W=Wholesale, R=Retail, M=Manufacturing):
Date Reported as work related:

Michigan
Federal ID Number:

Minnesota
Date employer notified of lost time:
NAICS Code Number:

Mississippi – No Additional State Questions

Missouri – No Additional State Questions

Montana – No Additional State Questions

Nebraska – No Additional State Questions

Nevada
How long employed by you in Nevada… Years: Months:
If Validity of Claim is Doubted, state Reason:

WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS

New Hampshire

Federal I.D. Number:
Was the employee injured in his/her regular occupation (Y/N):
Was injured hired in New Hampshire (Y/N):
Number of Full-Time Employees:
Number of Part-Time Employees:
If leased or temporary worker, provide the Client's Business Name:
Was accident caused by injured's failure to use safeguards or follow regulations (Y/N):
Probable Length of Disability:
Returned to work (Y/N):
At what Occupation:
Returned at Full Duty:
Returned at Alternative/Light Duty:
Initial treatment ("X" all that apply)…
No medical treatment: Care provided by employer only (on-site):
Emergency Care: Hospitalized: Outpatient: Clinic:
Office Visit: Other-explain:
Is there a managed care program (Y/N):
If Yes, Name of Provider:
Is there a written safety program in force (Y/N):
Is there an active safety committee (Y/N):
Employee's Legal First Name (please validate):

New Jersey – No Additional State Questions

New Mexico – No Additional State Questions

New York

Did you provide medical care (Y/N):
If Yes, When:
Returned to work (Y/N):
If Yes, at what Weekly Wage $:
Injured workers Work Week (indicate days regularly worked):
Fatal (Y/N):
If Yes, Name and Address of nearest relative:
Relationship:

North Carolina

Regular Wages per Day $:
Average Weekly Wages with Overtime $:
Returned to work (Y/N):
If Yes, at what Time: AM/PM
If Yes, what Date:
Return to work at what Wage $: Per (Day, Week or Month):
Return to work at what Occupation:

North Dakota – No Additional State Questions

Ohio

Time Accident Reported to employer: AM/PM:
Has employee ever filed a previous application for this injury (Y/N):
Has employee filed any other claims with the Bureau or Industrial Commission (Y/N):
If Yes, specify Claim Number and Body Parts:
Employee's County:
Current Employer's Risk Number:

Oklahoma

Was employment agreement made in Oklahoma (Y/N):
SIC Number:
Type of Ownership (P=Private, S=State Government, C=County Government, L=Local Government):

Oregon

Hospitalized overnight as inpatient (if emergency room only, answer N) (Y/N):
Was accident caused by failure of machinery or product (Y/N):
Did someone (not worker) cause accident (Y/N):
Time worker left work: AM/PM:

Pennsylvania

Employee's County:
Bureau Code:
NAICS Code:
Employer's County:
Are you aware of a 'Panel of Physicians' for your Employer(Y/N)

Rhode Island

Federal ID Number:
First Full Day Lost from work:
Unemployment Insurance Number:
State of Hire:
Was this injury previously an "Incident Only" with no medical treatment and no lost time (Y/N):
If Yes, Date Employer first Notified of medical treatment or lost time:
Category of Injury or Illness ("X" all that apply):
Injury: Illness: Occupational Disease: Repetitive Trauma:
Occupational Hearing Loss: Unknown:

South Carolina – No Additional State Questions

South Dakota

Federal ID Number:
Number of employees:
Body Part Injured Code (2 digits):
Cause of Injury Code (2 digits):
Nature of Injury Code (2 digits):
Was employee hired for temporary employment (Y/N):
Carrier Code:

Tennessee – No Additional State Questions

Texas – No Additional State Questions

Utah – No Additional State Questions

Vermont

Federal ID Number:
Was employee hired in Vermont (Y/N):
Does the employer regularly employ 10 or more employees (Y/N):
Returned to work (Y/N): If Yes, at what Weekly Wage $:
Was injured paid in full for the date disability began (Y/N):
Was employee injured at his/her regular occupation (Y/N):
Fatal (Y/N):
If Yes, Name, Address and Relationship of Nearest Relative:
Last Date Paid in Full:

Virginia

Returned to work (Y/N): If Yes, at what Wage $:
Federal Tax ID Number:

Washington – No Additional State Questions

West Virginia

Has the employee been given 'The Employees and Physicians Report of Injury Form' (Y/N)

Wisconsin – No Additional State Questions

Wyoming – No Additional State Questions

U.S. Longshoreman (USDOL) – No Additional State Questions