THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKERS' COMPENSATION LAW

WC Form 2
Rev. 1-93

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

OMBUDSMAN 1—800—528—5166

Send to: Your workers' compensation insurance carrier, in duplicate

PRINT OR TYPE

EMPLOYER

1. EMPLOYER'S NAME AND MAILING ADDRESS (As shown on Insurance Policy or S. I. Certificate) (No. & Street, City, County, State, ZIP)

TELEPHONE NUMBER

LOCATION, IF DIFFERENT FROM MAILING ADDRESS

2. EMPLOYER IDENTIFICATION (U. C. ACCOUNT) NUMBER

3. CARRIER OR SELF-INSURANCE REGISTRATION NUMBER

4. NATURE OF BUSINESS (Manufacturing, Trade, Transportation, etc.)

SPECIFIC PRODUCTS

5. WORKERS' COMPENSATION PROVIDED BY: INSURANCE CARRIER ( ) SELF-INSURANCE ( ) GROUP FUND ( )
IF INSURANCE CARRIER, GIVE NAME AND ADDRESS:

EMPLOYEE

6. EMPLOYEE'S NAME (Last) (First) (Middle)

7. SEX MALE ( ) FEMALE ( )

8. AGE

9. SOCIAL SECURITY NO.

10. EMPLOYEE'S HOME ADDRESS (No. & Street or RFD, City, County, State, ZIP)

11. MARITAL STATUS: SINGLE ( ) MARRIED ( ) DIVORCED ( ) SEPARATED ( ) WIDOWED ( )

12. HOME TELEPHONE

13. REGULAR OCCUPATION

14. WORKING IN WHAT DEPARTMENT WHEN HURT

INJURY OR ILLNESS

15. PLACE OF ACCIDENT OR EXPOSURE (Address or location, include County)

16. ON EMPLOYER'S PREMISES? YES ( ) NO ( )

17. Date of Occurrence

18. TIME OF DAY a.m. ( ) p.m. ( )

19. Date Disability Began

20. Date Employer Notified

21. DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
(E.g., amputation of right index finger at second joint, fracture of 2 ribs, lead poisoning, dermatitis of left hand, etc.)

22. IF FATAL, GIVE DATE OF DEATH

23. WHAT THING DIRECTLY PRODUCED THIS INJURY OR ILLNESS?
(Name object struck against or struck by; vapor, poison, chemical or radiation; if strain or hernia, the thing being lifted, pulled, pushed, etc.; if injury resulted solely from bodily motion, the stretching, twisting, etc. which resulted in injury.)

24. HOW DID THE ACCIDENT OR EXPOSURE OCCUR?
(Begin by telling what the employee was doing just before the accident or exposure. Be specific. If employee was using tools or equipment, or handling material, name them and tell what employee was doing with them.)

(Now describe fully the events which resulted in injury or illness. Tell what happened and how it happened. Specify how objects or substances were involved. Give full details of all factors which led or contributed to the accident or exposure.)

25. NAME AND ADDRESS OF TREATING PRACTITIONER

NAME AND ADDRESS OF HOSPITAL

HOSPITALIZED ( )
OUT-PATIENT ( )
EMERGENCY TREATMENT ( )

WAGE INFORMATION

26. Has Injured Returned to Work? Yes ( ) No ( )

27. If so, Date

28. At What Wage?

29. At What Occupation?

30. LENGTH OF TIME IN YOUR EMPLOY?
Years_____ Months_____

31. LENGTH OF TIME IN PRESENT JOB
Years_____ Months_____

32. NUMBER OF DEPENDENTS

33. Average Weekly Wage

34. Weekly Value of Remuneration Other Than Wages-(Food, Lodging, etc.)
$

35. DID EMPLOYEE RECEIVE FULL PAY FOR DAY OF INJURY? YES ( ) NO ( )

36. Date of This Report

37. Signed by

38. Signature

39. Official Position or Title

Do Not Write In The Space Below

Employer U. C. ←

Carrier Number ←

SIC

Carrier-Fund

Soc. Sec. No. ←

Sex

Marital Status

Dependents

Age

Occupation

Event County

On Premises

Event Date

Paid Day Injury

Employer Knew

Injury Source

Accident Type

Nature of Injury

Part of Body

Date of Death

Stopped Work

Time Employed

Time in Job

Weekly Wage

Report Date

Report Received

Back to Work

Case Class