FIRST REPORTS ONLY: FAX to: (203) 294-0082 E-Mail to: 1STREPORT@wctrust.com Online at: www.wctrust.com Phone: (866) 730-1143 GENERAL INFORMATION NUMBER (800) 506-2655	Workers' Compensation trust® PO BOX 5042, WALLINGFORD, CT 06492 **EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE** (PLEASE TYPE OR PRINT IN INK)	REASON FOR REPORT: CHECK ONE RO- RECORD ONLY ☐ MO - MEDICAL ONLY ☐ LT - LOST TIME (1 DAY OR MORE) ☐

INSTRUCTIONS: The Supervisor, NOT the injured employee, must complete this report immediately after an accident/injury has been reported.

EMPLOYER INFORMATION

EMPLOYER NAME, MAILING ADDRESS **Policy #**	STREET ADDRESS (if different from Mailing Address)	NATURE OF BUSINESS
PHONE		

EMPLOYEE INFORMATION

EMPLOYEE NAME (First, Middle Initial and Last)	SOCIAL SECURITY	SEX	DATE OF BIRTH	AGE

EMPLOYEE ADDRESS (Number, Street, City, State and Zip)	MARITAL STATUS	NUMBER OF DEPENDENTS

HOME PHONE (Include Area Code)	OCCUPATION (Position/Title)	DEPARTMENT	WORK PHONE (Include Area Code)

TIME EMPLOYEE BEGINS WORK		NUMBER OF HOURS WORKED PER DAY	NUMBER OF DAYS WORKED PER WEEK	WEEKLY WAGES (At Time of Injury)
AM	PM			

DATE OF HIRE	IMMEDIATE SUPERVISOR	SUPERVISOR'S PHONE (Include Area Code)

INJURY OR EXPOSURE INFORMATION

DATE OF INJURY	TIME OF INJURY		PLACE WHERE INJURY/EXPOSURE OCCURRED (Include City)	WAS THIS EMPLOYER'S PREMISES?
	AM	PM		

OBJECT CAUSING INJURY (Client, Door, Needle, etc.)	TYPE OF INJURY (Burn, Cut, Bite, Strain, Exposure, etc)	PART OF BODY INJURED(Right Leg,Back,Left Ankle,etc)

DESCRIBE THE EVENTS WHICH RESULTED IN THE INJURY OR DISEASE (Give full details on all factors that led or contributed to the injury or the disease)

NAME AND ADDRESS OF ANY WITNESS(ES)	WITNESS(ES) TELEPHONE No (Include Area Code)

WAS TREATMENT SOUGHT IN EMERGENCY ROOM? (Yes or No)	DATE EMPLOYER NOTIFIED

NAME AND ADDRESS WHERE TREATMENT SOUGHT (if known)	WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? (Yes or No) NAME AND ADDRESS OF HOSPITAL (if hospitalized)

	DATE LOST TIME BEGAN	HAS EMPLOYEE RETURNED TO WORK?	IF YES, RETURN TO WORK DATE
FOR OCCUPATIONAL DISEASE:	DATE OF LAST EXPOSURE	DID EMPLOYEE DIE? (Yes or No)	DATE OF DEATH

PREPARER INFORMATION

PREPARER'S NAME AND TITLE (Type or Print)	PHONE NUMBER (Include Area Code)	DATE PREPARED