


TO REPORT A CLAIM: FAX to: (203) 294-0082 E-Mail to: 1STREPORT@wctrust.com Phone: (800) 506-2655 GENERAL INFORMATION: (203) 678-0100 OR 1-866-600-0258	 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 <input type="checkbox"/> MO - MEDICAL ONLY <input type="checkbox"/> LT - LOST TIME (1 DAY OR MORE) <input type="checkbox"/>
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INSTRUCTIONS: The Supervisor, **NOT** the injured employee, must complete this report immediately after an accident/injury has been reported.

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 AM <input type="checkbox"/> PM <input type="checkbox"/>		NUMBER OF HOURS WORKED PER DAY	NUMBER OF DAYS WORKED PER WEEK	WEEKLY WAGES (At Time of Injury)
DATE OF HIRE	IMMEDIATE SUPERVISOR		SUPERVISOR'S PHONE (Include Area Code)	

INJURY OR EXPOSURE INFORMATION

DATE OF INJURY	TIME OF INJURY AM <input type="checkbox"/> PM <input type="checkbox"/>		PLACE WHERE INJURY/EXPOSURE OCCURRED (Include City)	WAS THIS EMPLOYER'S PREMISES?
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)				
IS THERE ADDITIONAL INFORMATION THE TRUST SHOULD BE AWARE OF? Yes <input type="checkbox"/> No <input type="checkbox"/>				
ARE THERE ANY CIRCUMSTANCES THAT WOULD WARRANT FURTHER INVESTIGATION? Yes <input type="checkbox"/> No <input type="checkbox"/>				
NAME AND PHONE NUMBER OF ANY WITNESS(ES)				
WAS TREATMENT SOUGHT IN EMERGENCY ROOM? Yes <input type="checkbox"/> No <input type="checkbox"/>			DATE EMPLOYER NOTIFIED	
NAME AND ADDRESS WHERE TREATMENT SOUGHT (if known)		WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>			DATE OF DEATH	

PREPARER INFORMATION

PREPARER'S NAME AND TITLE (Type or Print)	PHONE NUMBER (Include Area Code)	DATE PREPARED
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Serious injuries should be reported 24 hours a day by dialing 1-800-506-2655.