



DEPARTMENT OF INDUSTRIAL ACCIDENTS  
 EMPLOYER'S NOTIFICATION TO INSURER OF MEDICAL ONLY INJURIES

If An Injury Has Resulted in 5 or More Lost Work Days,  
 File "Employer's First Report of Injury", Form 101

DO NOT File This Form With  
 The Department of  
 Industrial Accidents

PLEASE PRINT OR TYPE:

EMPLOYEE	1. Employee Name (Last, First, MI)		2. Home Telephone ( ) -	3. Social Security Number* - -
	4. Home Address (No. & Street, City, State, Zip Code)		5. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	6. No. of Dependents
	7. Date of Hire (MM/DD/YY): / /	8. Date of Birth (MM/DD/YY): / /	9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	10. Hourly Wage
	11. Piece or Hourly Worker? <input type="checkbox"/> Piece <input type="checkbox"/> Hourly	12. Hours Worked Per Day	13. Days Worked Per Week	14. Avg. 52-Week Wage: \$ <input type="checkbox"/> Estimated or <input type="checkbox"/> Actual

EMPLOYER	15. Employer Name		16. Employer Self-Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Federal Tax ID -
	18. Employer Address (No. & Street, City, State, Zip Code)		19. Employer Telephone ( ) -	20. Industry Code
	21. Insurance Carrier: Name and Address of Branch Responsible for This Case (Not Local Agent or Adjuster)			
	22. Worker's Compensation Policy Number		23. OSHA Case File Number (if applicable)	

INJURY INFORMATION	24. Date of Injury (MM/DD/YY): / /	25. Time of Injury : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	26. Source of Injury (e.g., Machine, Tool, Substance, etc.)	
	27. Address Where Injury Occurred (if different from #18 above)		28. On Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	29. Employer Location Code
	30. Regular Occupation		31. Regular Occupation When Injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	32. To Whom Was Injury Reported?			33. Date Reported (MM/DD/YY): / /
	34. Nature of Injury(ies) (Burn, Fracture, Cut, etc.)			
	35. Injured Body Part(s) Description (Arm, Leg, Back, etc.)			
	36. Physician Name and Address			
	37. Hospital Name and Address			
	38. Describe How Injury Occurred (e.g., Struck by....., Fell from....., Exposed to...)			
	39. If Employee Has Returned to Work, Date of Return (MM/DD/YY): / /		40. Returned to Regular Occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No	

41. Preparer's Name (Please Print or Type)		42. Preparer's Title	
43. Preparer's Signature			44. Date Prepared (MM/DD/YY): / /

\*Disclosing Social Security Number is voluntary.