



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
REPORT OF INJURY

P.O. Box 58
 Jefferson City, MO 65102-0058

(To complete form,
 see attached instructions)

GENERAL	EMPLOYER (NAME, ADDRESS, INCL ZIP CODE)		CARRIER ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE	
	JURISDICTION		JURISDICTION CLAIM NUMBER			
	INSURED REPORT NUMBER					
	EMPLOYERS LOCATION ADDRESS (IF DIFFERENT)			LOCATION #		
	SIC CODE	EMPLOYER FEIN				PHONE #
CARRIER CLAIMS ADMIN	CARRIER (NAME, ADDRESS & PHONE NO.)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)		
			to			
	CARRIER FEIN		INSURANCE POLICY NUMBER	ADMINISTRATOR FEIN		
	AGENT NAME & CODE NUMBER					
EMPLOYEE	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY #	DATE HIRED	STATE OF HIRE
	ADDRESS (INCLUDE ZIP)		SEX	MARITAL STATUS		OCCUPATION JOB TITLE
			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> UNMARRIED SINGLE DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		EMPLOYMENT STATUS
	PHONE #	# OF DEPENDENTS			NCCI CLASS CODE	
WAGE	RATE	PER <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER	# OF DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
				DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
OCCURRENCE	TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
	CONTACT NAME PHONE NUMBER		TYPE OF INJURY ILLNESS		PART OF BODY AFFECTED	
	DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE	
	ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		
	SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		
	HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.					CAUSE OF INJURY CODE
	DATE RETURN TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO		WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	PHYSICIAN HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT	
WITNESS (NAME & PHONE #)				<input type="checkbox"/> 0 - NO MEDICAL TREATMENT <input type="checkbox"/> 1 - MINOR: BY EMPLOYER <input type="checkbox"/> 2 - MINOR CLINIC HOSPITAL <input type="checkbox"/> 3 - EMERGENCY CASE <input type="checkbox"/> 4 - HOSPITALIZED > 24 HOURS <input type="checkbox"/> 5 - FUTURE MAJ. MED. LOST TIME ANTICIPATED		
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER	

NOTE > This form constitutes the detailed report of injury required by §287.380, RSMo Cum. Supp. (2005) and rules applicable thereto. An injury that requires immediate first aid, which does not result in further medical treatment or lost time from work, need not be reported to the Division. Employers should report all injuries to their workers' compensation insurance carrier or third-party administrator (TPA) within five days of the date of the injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. See §287.380, RSMo. If the employer has been granted self-insurance authority by the Division pursuant to §287.280, RSMo, and rules applicable thereto, please report all injuries to your TPA or Service Company to enable them to file this report with the Division.

PRINT QUALITY > All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division MUST be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

*Missouri Division of Workers' Compensation is an equal opportunity employer/program.
Auxiliary aids and services are available upon request to individuals with disabilities.*