EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

STATE EMPLOYEE INJURY COMPENSATION TRUST FUND (SEICTF)

Submit the online version of this form when possible by accessing our website, at www.riskmgt.alabama.gov. All questions on this form must be answered. A supervisor or other designated authority must complete this report and fax along with the Accident Report - Employee Statement form to 334-223-6170 or 888-827-6753 or submit via email to SEICTF@finance.alabama.gov. If you need assistance contact SEICTF at 800-388-3406, between 8 AM and 5 PM, Monday - Friday.

1. Name of Injured Employee Last First MI	2. SSN _____-____-_____	3. Date of Birth _____/_____/_____	4. Sex ❑ M ❑ F
5. Employee Mailing Address No. and Street City or Town State Zip	6.Employee Phone Home _____ Work _____ Cell _____ Employee Work Hours: From: _____ To: _____		
7. Job Title / Job Code	8. Employment Status ❑ Full Time ❑ Part Time ❑ Contract	9.Employee Email address	
10. Employing Agency - Agency Number	11. Division, District, Location, etc.		
12. Agency Address - Number and Street	City or Town	State	Zip

13. Date of Injury	14. Date Employer Notified	15. Time of Injury __:____ ❑ AM ❑ PM	16. On Agency Premises? ❑ Yes ❑ No	17. Is employee covered by State Employee Medical Insurance? ❑ Yes ❑ No

18. Could this accident have been prevented? ❑ Yes ❑ No	If yes, what steps have been taken to prevent another accident?

19. Has the injury or illness resulted in medical treatment? ❑ Yes ❑ No

If yes, name and address of medical provider/facility.

20. Exact location where injury occurred include street address, building, room, parking lot, etc., if possible.

21. Was injury caused by a motor vehicle accident? ❑ Yes ❑ No If yes, provide copy of police report to SEICTF.

22. Was more than one person injured in this incident? ❑ Yes ❑ No	If yes, provide name(s):

23. Describe exactly what the injured employee was doing and how the accident occurred.

24. Describe the injury (ies) received. Indicate if cut, bruise, sprain, strain, twist, pull, etc. (Give details below):

_____

_____

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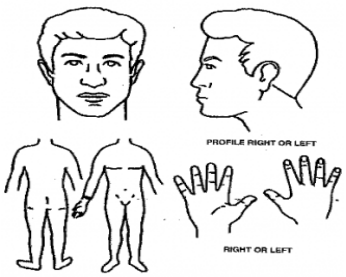
_____

_____

_____



Indicate the body part(s) affected below and by circling on the body chart at left.

❑ Head	❑ Eye(s)
❑ Left Hand	❑ Right Hand
❑ Left Leg	❑ Right Leg
❑ Back	❑ Neck
❑ Left Foot	❑ Right Foot
❑ Left Knee	❑ Right Knee
❑ Left Ankle	❑ Right Ankle

❑ Other _____

25. Name all witnesses (Use additional paper as necessary):

Name _____ Daytime Phone _____

Name _____ Daytime Phone _____

I am the supervisor of the employee making the claim for SEICTF benefits and have filled out this First Report of Injury based on the information that has been reported to me. I certify that the above information is true and correct to the best of my knowledge.

26. Signature of supervisor reporting incident	Print Name	Daytime Phone	Date