## EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

RETURN COMPLETED FORM TO (334) 263-1976 OR CLAIMS@ALABAMARETAIL.ORG

CLAIM REFERENCE								
FEDERAL TAX ID NUMBER (REQUIRED): INSURED MEMBER NUMBER:								
EMPLOYER								
Employer Legal Name:					ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS:			
Physical Address 1:				Mailing Address 1:				
Physical Address 2			<b></b> -	Mailing A	ddress 2:	<b>C.</b> .	<del></del> -	
City:	Sta	ite:	Zip:	City:	NE .	State:	Zip:	
INSURER / FILING OFFICE								
Insurer Name: Alabama Retail Comp Mailing Address: P.O. Box 240549					Filing Office Phone: (800) 239-5423 Filing Office Fax: (334) 263-1976			
City: Montgomery State: AL Zip: 36124					Filing Office Email: claims@alabamaretail.org			
EMPLOYEE / WAGES								
First Name:				T				
Last Name:					EMPLOYEE SSN:			
Last Name Suffix (	Ex:. Jr., Sr., III):			١,	DATE OF BIRTH:			
Preferred Name:								
Mailing Address 1:					Telephone:		Gender:	
Mailing Address 2:					Email:		Male Female	
City:		State:	Zip:				remale	
Occupation Descri	ption:				Employee Type W2	e: 099 🔲	Date of Hire:	
Wages:				I		Employee Statu	JS:	
Hourly Daily	Weekly B	i-Weekly	Monthly	Ι	Full Time Part Time			
Received Full Pay F	or Day of Injury?	Yes	No 🗌	Did Salary	y Continue Afte	er Accident? Y	es No	
			INJURY / TR	EATMENT				
DATE OF INJURY:		Time of Inj	·		ime Employee	Began Work:	Date of Death:	
			a.m. 🔲 p.m. 🔲 unl	k 🗌	a.m.	p.m		
Injury Occurred on	Employer's Premis	ses?		ENT, INJUI	RY, OR EXPOS	SURE (if different t	chan employer address):	
Yes No No			Site Address:					
– –	tified:		City:	State: Zip:				
Date Employer Notified: County:								
DESCRIBE IN DETAIL WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT, HOW THE INJURY OCCURRED, AND WHAT								
BODY PARTS WERE AFFECTED (INCLUDING RIGHT OR LEFT SIDE):								
Initial Treatment:								
Minor Clinic								
Date of Initial Evaluation/Medical Treatment:								
Name of Treatment Facility/Physician: Address: City: State: Zip:								
Telephone:			City	•		State.	ΣIP.	
Has Injured Employee Returned to Work: Yes No Date Injured Employee Returned to Work:								
Do you anticipate injured employee to miss more than 3 scheduled days of work? Yes No								
OTHER								
Date Prepared:	Preparer's Full Na	me:			Preparer's	Phone:		
	Job Title:				Preparer's			
	JOD TILLE.				Preparer's	Email:		

## **SUPPLEMENTAL REPORT OF INJURY**

PLEASE PROVIDE ANSWERS WHERE APPLICABLE

ADDITIONAL INJURY/TREATMENT DETAILS							
IF MULTIPLE BODY PARTS WERE INJURED, PLEASE PROVIDE A LIST OF THE BODY PART, LEFT OR RIGHT SIDE, AND INJURY (Example:							
Bruised Left Elbow):							
Did you authorize any medical treatment: Yes \( \text{No} \text{ No} \( \text{No}	d/requested: Yes No No						
If yes, explain:	If yes, explain:	plain:					
Are you aware of any pre-existing injury(s) or health issues related to the injury or injured body part: Yes No							
If yes, explain:							
WITNESSES / RESPONSIBLE PARTIES							
Any witnesses to the accident/injury: Yes \( \square\) No \( \square\)	Is there surveillance video of the accident/injury: Yes \( \text{No} \)						
Witness Name(s)/Phone(s):	If yes, please secure a copy of the video for future reference, if needed.						
Is a 3 <sup>rd</sup> party responsible or potentially responsible for the acciden	Yes No No						
If yes, explain or provide the name of the responsible party(s):							
Was there a malfunction of any equipment or machinery that ma accident/injury occurred?	Yes No N/A						
INVESTIGATION/SAFETY							
Was the injured employee performing his/her normal job duties	Yes No No						
Do you have any concerns or suspicions that the accident DID No injured employee?	Yes No No						
Are you aware of any <u>written</u> safety policy or guideline that was to or caused the accident/injury?	Yes No No						
CONTACT INFORMATION							
Who is the best person(s) at the business to contact about this claim moving forward?							
Name: Email:							
b Title: Phone:							
Do you have any immediate questions or concerns about this accident/injury that you need to discuss with our office?							
Yes 🔲 No 🔲 If yes, provide a brief explanation:							

Please forward any related documentation or correspondence you have received related to this accident/injury.

RETURN COMPLETED FORM AND DOCUMENTATION TO (334) 263-1976 OR CLAIMS@ALABAMARETAIL.ORG