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:
Physical Address 1:
Physical Address 2:
City: State: Zip:

ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS:
Mailing Address 1:
Mailing Address 2:
City: State: Zip:

INSURER / FILING OFFICE

Insurer Name: *Alabama Retail Comp*
Mailing Address: *P.O. Box 240549*
City: *Montgomery* State: *AL* Zip: *36124*

Filing Office Phone: *(800) 239-5423*
Filing Office Fax: *(334) 263-1976*
Filing Office Email: *claims@alabamaretail.org*

EMPLOYEE / WAGES

First Name:
Last Name:
Last Name Suffix (Ex:. Jr., Sr., III):
Preferred Name:

EMPLOYEE SSN:

DATE OF BIRTH:

Mailing Address 1:
Mailing Address 2:
City: State: Zip:

Telephone:
Email:

Gender:
Male ☐
Female ☐

Occupation Description:

Employee Type:
W2 ☐ 1099 ☐

Date of Hire:

Wages:
Hourly ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐

Employee Status:
Full Time ☐ Part Time ☐

Received Full Pay For Day of Injury? Yes ☐ No ☐

Did Salary Continue After Accident? Yes ☐ No ☐

INJURY / TREATMENT

DATE OF INJURY:

Time of Injury:
a.m. ☐ p.m. ☐ unk ☐

Time Employee Began Work:
a.m. ☐ p.m. ☐

Date of Death:

Injury Occurred on Employer's Premises?
Yes ☐ No ☐
Date Employer Notified:

PLACE OF ACCIDENT, INJURY, OR EXPOSURE (if different than employer address):
Site Address:
City: State: Zip:
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 ☐ Emergency Room ☐ Hospitalized >24 Hours ☐ No Medical Treatment ☐ First Aid by Employer ☐

Date of Initial Evaluation/Medical Treatment:

Name of Treatment Facility/Physician:
Address: City: State: Zip:
Telephone:

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 Name:
Job Title:

Preparer's Phone:
Preparer's Fax:
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 ☐ No ☐ If yes, explain:	Is follow-up medical treatment needed/requested: Yes ☐ No ☐ If yes, explain:

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 ☐ No ☐ Witness Name(s)/Phone(s):	Is there surveillance video of the accident/injury: Yes ☐ No ☐ ***If yes, please secure a copy of the video for future reference, if needed.***

Is a 3rd party responsible or potentially responsible for the accident/injury?	Yes ☐ No ☐
If yes, explain or provide the name of the responsible party(s):	
Was there a malfunction of any equipment or machinery that may have been in use when the accident/injury occurred?	Yes ☐ No ☐ N/A ☐

INVESTIGATION/SAFETY

Was the injured employee performing his/her normal job duties at the time of the accident/injury?	Yes ☐ No ☐
Do you have any concerns or suspicions that the accident DID NOT occur at work as reported by the injured employee?	Yes ☐ No ☐
Are you aware of any <u>written</u> safety policy or guideline that was violated which may have contributed to or caused the accident/injury?	Yes ☐ No ☐

CONTACT INFORMATION

Who is the best person(s) at the business to contact about this claim moving forward?

Name: Email:

Job 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