

WC Form 2  
Rev. 1-93

STATE OF ALABAMA  
EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE  
OMBUDSMAN 1-800-528-5166

Send to: Your workers' compensation insurance carrier, in duplicate

PRINT OR TYPE

EMPLOYER	1. EMPLOYER'S NAME AND MAILING ADDRESS (As shown on Insurance Policy or S.I. Certificate) (No. & Street, City, County, State, ZIP)		LOCATION, IF DIFFERENT FROM MAILING ADDRESS		Do Not Write In The Space Below	
	TELEPHONE NUMBER					Employer U. C.
	2. EMPLOYER IDENTIFICATION (U. C. ACCOUNT) NUMBER		3. CARRIER OR SELF-INSURANCE REGISTRATION NUMBER			Carrier Number
	4. NATURE OF BUSINESS (Manufacturing, Trade, Transportation, etc.)		SPECIFIC PRODUCTS			SIC
	5. WORKERS' COMPENSATION PROVIDED BY: INSURANCE CARRIER    SELF-INSURANCE    GROUP FUND AND ADDRESS: <b>Construction Claims Management, Inc. * P. O. Box 5620, Montgomery, AL 36103 * TPA #50092</b>					Carrier-Fund
EMPLOYEE	6. EMPLOYEE'S NAME (Last) (First) (Middle)		7. SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	8. AGE	9. SOCIAL SECURITY NO.	
	10. EMPLOYEE'S HOME ADDRESS (No. & Street or RFD, City, County, State ZIP)			11. MARITAL STATUS: SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		
	12. HOME TELEPHONE	13. REGULAR OCCUPATION		14. WORKING IN WHAT DEPARTMENT WHEN HURT		
	15. PLACE OF ACCIDENT OR EXPOSURE (Address or location, include County)		16. ON EMPLOYER'S PREMISES? YES <input type="checkbox"/> NO <input type="checkbox"/>			
17. Date of Occurrence	18. TIME OF DAY a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	19. Date Disability Began		20. Date Employer Notified		
21. DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED. (E.g., amputation of right index finger at second joint, fracture of 2 ribs, lead poisoning, dermatitis of left hand, etc.)					Occupation	
22. IF FATAL, GIVE DATE OF DEATH					Event County	
23. WHAT THING DIRECTLY PRODUCED THIS INJURY OR ILLNESS? (Name object struck against or struck by; vapor, poison chemical or radiation; if strain or hernia, the thing being lifted, pulled, Pushed, etc.. if injury resulted solely from bodily motion, the stretching, twisting, etc. which resulted in injury.)					On Premises	
24. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Begin by telling what the employee was doing just before the accident or exposure. Be specific. If employee was using tools or equipment, or handling material, name them and tell what employee was doing with them.)  (Now describe fully the events which resulted in injury or illness. Tell what happened and how it happened. Specify how objects or substances were involved. Give full details of all factors which led or contributed to the accident or exposure.)					Event Date	
25. NAME AND ADDRESS OF TREATING PRACTITIONER					Paid Day Injury	
NAME AND ADDRESS OF HOSPITAL HOSPITALIZED <input type="checkbox"/> OUT-PATIENT <input type="checkbox"/> EMERGENCY <input type="checkbox"/> TREATMENT <input type="checkbox"/>					Employer Knew	
26. Has Injured Returned to Work? Yes <input type="checkbox"/> No <input type="checkbox"/>					Injury Source	
27. If so, Date		28. At What Wage?		29. At What Occupation?		
23. Average Weekly Wage					Accident Type	
30. LENGTH OF TIME IN YOUR EMPLOY? Years _____ Months _____			31. LENGTH OF TIME IN PRESENT JOB Years _____ Months _____		Nature of Injury	
32. NUMBER OF DEPENDENTS					Part of Body	
33. Weekly Value of Remuneration Other Than Wages-(Food, Lodging, etc.) \$ _____					Date of Death	
34. DID EMPLOYEE RECEIVE FULL PAY FOR DAY OF INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/>					Stopped Work	
36. Date of This Report		37. Signed by		38. Signature		
39. Official Position or Title					Time Employed	
					Time in Job	
					Weekly Wage	
					Report Date	
					Report Received	
					Back to Work	
					Case Class	

## INSTRUCTIONS FOR FILING WC CLAIM FORMS

### Employer's First Report of Injury

Employers should send a completed, original, legible form signed in ink to the insurance carrier or, if self-insured, to the designated office handling their workers' compensation claims. The insurance carrier or designated office should forward this First Report on to this Division so that it reaches the Workers' Compensation Division, Department of Industrial Relations, Montgomery, AL 36131 within fifteen (15) days from the date of injury or date of notification to the employer for all injuries for which compensation is claimed or paid. This includes deaths, permanent disabilities or temporary disabilities exceeding three (3) days.

Block 1. Name and address exactly as shown on the WC policy or the group self-insurance certificate issued to that employer. The block on the right side should give the location where the employee was working if that is different from the left side.

Block 2. Employer's ten digit Unemployment Compensation Tax Account number which is shown on the employer's form UC CR4 Quarterly Contribution and Wage Report which is filed with the State Unemployment Compensation Agency.

Block 3. I.D. number for insurance carrier or group self-insurance certificate.

Block 4. Self-explanatory.

Block 5. Place a check mark in one of the parenthesis and give name, mailing address and five digit I. D. number.

Block 6. Be sure last name is first followed by a comma and then first name and middle name.

Block 7. Self-explanatory.

Block 8. Age only. Do not put birth date.

Blocks 9 through 20. Self-explanatory.

Blocks 30 and 31. Years and months. Do not put dates here.

Block 32. Include spouse if applicable.

Block 33. Average of weekly gross wages. The average weekly wage should be the average of total remuneration received by the employee for the year just prior to the injury. These earnings are those subject to federal income taxation and reportable on the Federal W-2 including voluntary contributions by the employee to a tax-qualified retirement program, voluntary contributions to a Section 125 cafeteria program and fringe benefits. Fringe benefits are **NOT** to be included **IF** the employer continues these benefits during the period of time for which compensation is paid.

Block 34. Weekly value of anything given in lieu of wages.

Block 35. Indicate whether or not employee received a full day's wages for the date of injury.

Blocks 36 through 39. Self-explanatory.

Be sure to date the report and sign it in ink in a legible manner. (If your signature is not legible, please type your name under the line.)