

**ALL COPIES OF FIRST REPORT MUST BE TYPED OR PRINTED**

Department of Labor  
Office of Workers' Compensation  
4425 North Market Street  
Wilmington, DE 19802

**STATE OF DELAWARE  
FIRST REPORT  
OF  
OCCUPATIONAL INJURY  
OR DISEASE**

CASE OR FILE NO. \_\_\_\_\_

Department of Labor  
Office of Workers' Compensation  
P.O. Box 8902  
Wilmington DE 19899-8902  
Telephone 302-761-8200

MIDDLE	LAST	EMPLOYER'S UC REPORTING NUMBER
		2. EMPLOYEE SOCIAL SECURITY NO.

<b>EMPLOYEE</b>	3. ADDRESS - INCLUDE COUNTY AND ZIP CODE			4. GENDER MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	5. EMPLOYEE TELEPHONE NUMBER (INCLUDE AREA CODE)
	6. DATE OF BIRTH	7. AGE	8. WAGE	9. WEEKLY HOURS WORKED	
	10. OCCUPATION (REGULAR)		11. DEPARTMENT OF DIVISION REGULARLY EMPLOYED		12. HOW LONG EMPLOYED

<b>EMPLOYER</b>	13. EMPLOYER			14. PERSON MAKING OUT THIS REPORT	
	15. ADDRESS - INCLUDE COUNTY AND ZIP CODE			16. EMPLOYER TELEPHONE NUMBER (INCLUDE AREA CODE)	
	17. MAILING ADDRESS - IF DIFFERENT THAN ABOVE		18. NATURE OF BUSINESS - TYPE OF MFG., TRADE, CONSTRUCTION, SERVICE, ETC.		

<b>DATES</b>	19. DATE OF REPORT	20. DATE OF INJURY AND TIME	21. NORMAL STARTING TIME	22. IF EMPLOYEE BACK TO WORK GIVE DATE	23. AT SAME WAGE
	- -	- - <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	- -	YES <input type="checkbox"/> NO <input type="checkbox"/>
	24. IF FATAL INJURY, GIVE DATE OF DEATH.	25. DATE EMPLOYER KNEW OF INJURY	26. DATE DISABILITY BEGAN	27. LAST FULL DAY PAID - DATE	
	- -	- -	- -	-- -	

<b>INJURY OR DISEASE</b>	28. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.				
	29. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.				

<b>OCCURRENCE</b>	30. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE WAS USING WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.				
	31. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, I.E.				
	32. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED				
	33. NAME OF PHYSICIAN			34. PHYSICIAN'S ADDRESS	
	35. HOSPITAL (IF APPLICABLE)			36. HOSPITAL ADDRESS	

**(THIS SECTION MUST BE COMPLETED IN ORDER TO PROCESS)**

**37. WORKERS' COMPENSATION INSURANCE COMPANY NAME, COMPLETE ADDRESS AND TPA (if applicable)**

I.A.B. CODE \_ \_ \_ \_ \_

**DISTRIBUTION OF THIS REPORT (1 original and 3 copies)**

- 1. ORIGINAL MUST BE SENT IMMEDIATELY TO WORKER'S COMPENSATION INSURANCE CARRIER.**
- 2. COPY TO INDUSTRIAL ACCIDENT BOARD**
- 3. EMPLOYER'S COPY - RETAIN AS RECORD**
- 4. EMPLOYEE'S COPY**

SIGNATURE OF PERSON IN 14 ABOVE \_\_\_\_\_

OFFICIAL POSITION \_\_\_\_\_

# **WORKERS' COMPENSATION**

## **IMPORTANT THINGS TO DO IN CASE OF INJURY**

### ***THE EMPLOYER SHOULD:***

1. Provide all necessary medical, surgical and hospital treatment from the date of accident.
2. Every employer shall keep a record of all injuries received by employees and make a report within 10 days thereof in writing to the Office of Workers' Compensation
3. Ascertain the average weekly wages of the employee and provide compensation in accordance with the provisions of the law, for disability *beyond the third day* after the accident. All agreements as to compensation must be submitted to the Office of Workers' Compensation for approval.

### ***THE EMPLOYEE SHOULD:***

1. Immediately notify the employer in writing of accidental injury or occupational disease and request medical services. Failure to give notice or to accept medical services may deprive the employee of the right to compensation.
2. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the law, file application with the Industrial Accident Board for a hearing on the matters at issue within two years of the date of accidental injury or one year of knowledge of the diagnosis of an occupational disease or an ionizing radiation injury. All forms can be obtained from the Office of Workers' Compensation.