EMPLOYER'S REPORT OF INJURY

WORKFORCE SAFETY & INSURANCE
CLAIMS DIVISION
SFN 13660 (04/2003)

WSI Help*Line*
1-800-777-5033
Questions? Call us. Report Injuries Immediately.

ND Fraud and Safety Hotline
1-800-243-3331
Report Fraud and Unsafe Work Conditions.

1600 EAST CENTURY AVENUE, SUITE 1
PO BOX 5585
BISMARCK ND 58506-5585
TELEPHONE NUMBER (701) 328-3800
FAX NUMBER FAX (701) 328-3820
OR TOLL FREE 1-888-786-8695
TDD NUMBER (for the hearing impaired only)
(701) 328-3786
www.WorkforceSafety.com

PLEASE PRINT OR TYPE USING BLACK OR BLUE INK

PART 1 **INJURED WORKER COMPLETE THIS PART OF FORM FOR ALL CLAIMS AND SIGN THE C1 FORM**

Claim Number	Employer Acct. No.	Social Security No.	Injury Date	Birth Date	Sex ☐F ☐M	Marital Status ☐Single ☐Married

Injured Worker's Name	Time of Injury ☐AM ☐PM	Employer's Name	Employer's Phone Number

Injured Worker's Address	Injured Worker's Phone Number	Employer's Address

Exact address or location of injury - (city, county, state, and zip)	If this injury occurred outside North Dakota, when did you last work in North Dakota prior to this injury? (MM/DD/YYYY)

What were you doing when injury occurred? How did it happen? Describe:

What is your occupation? (job title or duties)	Date employer notified, and who did you notify

Part of body injured (specify right or left, if applicable)	**Have you had prior problems or injuries to that part of the body?** Please complete the attached C16 (Prior Injury Questionnaire) ☐Yes ☐No

Type of injury (fracture, bruise, cut, etc.)	Date of first treatment	How long worked for employer? ☐Days ☐Weeks ☐Months ☐Years	Years of education (circle one) 8 or less 9 10 11 12 13 14 15 16+

Treating doctor(s) name and facility / clinic(s) address

Doctor(s) / Hospital(s) and facility address

Witness(es) to the injury	Witness(es) address

PART 2 **EMPLOYER COMPLETE PART 2, PART 3 AND PART 4, THEN SIGN AND DATE FORM, AND SEND TO WORKFORCE SAFETY & INSURANCE (WSI).**

Employer's name, address, city, state, and zip code	Telephone No.	Work Comp Acct. No.	Worker's Rate Class

If this injury occurred outside North Dakota, when did injured worker last work in North Dakota prior to this injury? (MM/DD/YYYY)

IMPORTANT **If you question this claim, state reason** (continue on back)

FRAUD WARNING **FRAUD WARNING** **FRAUD WARNING**

By signing this form I acknowledge that I have read the Fraud Warning on the reverse side of this form and understand that falsifying this claim or making a false statement regarding this claim may be a FELONY, punishable by substantial fines and imprisonment. By my signature below, I declare that the statements on this form are true and accurate.

I have the authority to execute this report.

Employer's Signature _____ Title _____ Date Signed _____

PART 3 **EMPLOYER COMPLETE THIS PART OF FORM FOR ALL CLAIMS**

Date of Hire (MM/DD/YYYY)	In which state was worker hired to work in?

Is injured worker a Corp. Officer, Owner or Partner, or Family Member? ☐Yes ☐No	
Did worker return to next scheduled shift after injury? ☐Yes ☐No	
Do you have modified duty available? ☐Yes ☐No	
Employment status ☐Full-time ☐Part-time ☐Temporary ☐Seasonal* (*defined as a job that has periods of 45 consecutive days of not receiving wages)	Season length in months?

PART 4 EMPLOYER COMPLETE THIS PART OF FORM ONLY IF WORKER WILL BE OFF THE JOB FOR FIVE OR MORE CONSECUTIVE DAYS

IMPORTANT Days worked per week? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

Working shift From ☐AM ☐PM To ☐AM ☐PM	
Date left work (MM/DD/YYYY)	Time left work ☐AM ☐PM
Wage ☐Hour ☑Week ☐Mile Rate $ Per ☐Day ☐Month	
Date of return to work (MM/DD/YYYY) ☐Estimated ☐Actual	**C2**

FRAUD WARNING - PENALTY FOR FILING FALSE CLAIMS WITH WORKFORCE SAFETY & INSURANCE (WSI).

Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for workers compensation benefits will FORFEIT ANY FUTURE BENEFITS and may be GUILTY OF A FELONY which is punishable by IMPRISONMENT, SUBSTANTIAL FINES, OR BOTH. These criminal penalties are applicable to ALL PERSONS dealing with the Fund, including INJURED WORKERS, EMPLOYERS, MEDICAL PROVIDERS, AND ATTORNEYS.

I ACKNOWLEDGE, by my signature on the front of this form, THAT I HAVE READ AND UNDERSTAND THE ABOVE DESCRIPTION OF THE PENALTIES FOR SUBMITTING A FALSE CLAIM FOR BENEFITS OR MAKING FALSE STATEMENTS TO WSI. I understand that WSI is relying upon the truth of my statements in awarding benefits or providing services on this claim. I CERTIFY THAT I HAVE NOT FILED A FALSE CLAIM, NOR MADE ANY FALSE STATEMENT, NOR KNOW OF ANY FALSE STATEMENT, MADE IN CONNECTION WITH THIS CLAIM FOR BENEFITS WITH WSI.