SAMPLE

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

REPORT OF INJURY

P.O. Box 58
Jefferson City, MO 65102-0058

(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*
(Your company name & address)

CARRIER ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)*
Complete if employee injured at a company location other than then one listed to the left

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*
MMMA SIWC Fund
16100 Chesterfield Pkwy West
Ste 210
Chesterfield, MO 63017

POLICY PERIOD ____ to ____

CHECK IF APPROPRIATE
☒ SELF INSURANCE

CLAIMS ADMINISTRATOR *(NAME, ADDRESS & PHONE NO.)*
Claims Management of Missouri, LLC
16100 Chesterfield Pkwy West
Ste 210
Chesterfield, MO 63017

CARRIER FEIN

INSURANCE POLICY NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)*

DATE OF BIRTH

SOCIAL SECURITY #

DATE HIRED

STATE OF HIRE

ADDRESS *(INCLUDE ZIP)*

SEX
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS
☐ UNMARRIED SINGLE DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION JOB TITLE

EMPLOYMENT STATUS
Full-time/part-time, etc.

PHONE #

OF DEPENDENTS

NCCI CLASS CODE

WAGE

RATE
Rate per week

PER ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER

OF DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY / ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME PHONE NUMBER
Contact person & Phone number at your company

TYPE OF INJURY ILLNESS
Be specific - strain, sprain laceration, contusion, etc

PART OF BODY AFFECTED
Be specific - right middle finger, left hand, right foot, right lower arm,etc

DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE
Claims Mgmt will complete

PART OF BODY AFFECTED CODE
Claims Mgmt will complete

ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
ZIP CODE where the accident happened

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.
Give detailed description of how injury occurred

CAUSE OF INJURY CODE
We will complete

DATE RETURN TO WORK
If applicable

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*
List Physician or Clinic

HOSPITAL *(NAME & ADDRESS)*
List Hospital if applicable

INITIAL TREATMENT
☐ 0 - NO MEDICAL TREATMENT
☐ 1 – MINOR: BY EMPLOYER
☐ 2 – MINOR CLINIC HOSPITAL
☐ 3 – EMERGENCY CASE
☐ 4 – HOSPITALIZED > 24 HOURS
☐ 5 – FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*

DATE ADMINISTRATOR NOTIFIED
Sent to Claims Mgt

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

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OF DEPENDENTS

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DATE OF INJURY / ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME PHONE NUMBER

TYPE OF INJURY ILLNESS

PART OF BODY AFFECTED

DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

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PHONE NUMBER