



**MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS  
DIVISION OF WORKERS' COMPENSATION  
REPORT OF INJURY**

P.O. BOX 58  
JEFFERSON CITY, MO 65102-0058  
(SEE INSTRUCTIONS ON PAGE 2)

**BOLD BOXES ARE MANDATORY**

<b>GENERAL</b>	EMPLOYER (NAME, ADDRESS, INCL ZIP CODE)		CARRIER ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE	
	SIC CODE		EMPLOYER FEIN	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER					
	EMPLOYERS LOCATION ADDRESS (IF DIFFERENT)			LOCATION #	PHONE #	
<b>CARRIER CLAIMS ADMIN</b>	CARRIER (NAME, ADDRESS & PHONE NO.)		POLICY PERIOD to	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)		
	CARRIER FEIN		POLICY SELF-INSURANCE NUMBER	ADMINISTRATOR FEIN		
	AGENT NAME & CODE NUMBER					
<b>EMPLOYEE</b>	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY #	DATE HIRED	STATE OF HIRE
	ADDRESS		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	OCCUPATION JOB TITLE	
	PHONE #	# OF DEPENDENTS	EMPLOYMENT STATUS		NCCI CLASS CODE	
	RATE PER <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER		# DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>OCCURRENCE</b>	TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE <input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE	
	DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			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					CAUSE OF INJURY CODE
	DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>TREAT- MENT</b>	PHYSICIAN HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT <input type="checkbox"/> 0 - NO MEDICAL TREATMENT <input type="checkbox"/> 1 - MINOR: BY EMPLOYER <input type="checkbox"/> 2 - MINOR CLINIC HOSPITAL <input type="checkbox"/> 3 - EMERGENCY CASE <input type="checkbox"/> 4 - HOSPITALIZED > 24 HOURS <input type="checkbox"/> 5 - FUTURE MAJ. MED. LOST TIME ANTICIPATED	
	WITNESS (NAME & PHONE #)					
<b>OTHERS</b>	DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER

**NOTE >** This form is both the notice and report of injury as required by Section 287.380, RSMo. Injuries that require only first aid and result in no lost time need not be reported. Please mail this report to your **WORKERS' COMPENSATION INSURANCE CARRIER** or Claims Administrator. If you are self-insured or are not under the Law and do not have an insurance carrier, mail this form to the Division.

**PRINT QUALITY >** All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division **MUST** be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

**TO BE ANSWERED ONLY IN CASE OF DEATH**

DATE OF DEATH

**EMPLOYEE'S DEPENDENTS**

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE