Minnesota Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road North
St. Paul, MN 55155-4305
(651) 284-5030

First Report of Injury

See Instructions on Reverse Side
Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

FR01

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA Case #

3. DATE OF CLAIMED INJURY	4. Time of injury ☑ am ☐ pm	5. Time employee began work on date of injury ☐ am ☑ pm

6. EMPLOYEE Name (last, first, middle)	7. Gender ☐ M ☐ F	8. Marital Status ☐ Married ☐ Unmarried

9. Home address	10. Home phone #	11. Date of birth

City	State	Zip Code	12. Occupation	13. Regular department	14. Date hired

15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week	19. Employment Status ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

20. Weekly value of:	Meals	Lodging	2nd Income	21. Apprentice ☐ Yes ☐ No

22. **Tell us how the injury occurred and what the employee was doing before the incident (give details).** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No If no, indicate name and address of place of occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI
	28. Date employer notified of injury	29. Date employer notified of lost time
	30. Return to work date	31. Date of death

32. TREATING PHYSICIAN (name, address, and phone)	33. HOSPITAL/CLINIC (name and address) (if any)	34. Emergency Room Visit ☐ Yes ☐ No
		35. Overnight in-patient ☐ Yes ☐ No

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)	
SOUTHERN PLAINS EDUCATION COOPERATIVE #0915		
38. **Mailing** address	39. Employer FEIN	40. Unemployment ID#
201 EAST 3RD STREET		
City / State / Zip Code	41. Employer's contact name and phone #	
FAIRMONT MN 56031		
42. **Physical** address (if different)	43. Witness (name and phone)	
City / State / Zip Code	44. NAICS code	45. Date form completed

46. **INSURER** name	51. **CLAIMS ADMIN COMPANY** (CA) name (check one) ☐ Insurer ☐ TPA
47. Insured legal name	52. CA address
48. Policy # or self-insured certificate #	City / State / Zip Code
49. Insurer FEIN / 50. Date insurer received notice	53. CA FEIN / 54. Claim #