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)	
38. **Mailing** address	39. Employer FEIN	40. Unemployment ID#
City State Zip Code	41. Employer's contact name and phone #	
42. **Physical** address (if different)	43. Witness (name and phone)	
City State Zip Code	44. NAICS code	45. Date form completed

46. **INSURER** name SFM Mutual Insurance Company	51. **CLAIMS ADMIN COMPANY** (CA) name (check one) ☑Insurer ☐TPA SFM Mutual Insurance Company	
47. Insured legal name	52. CA address Claim Services, Box 9416	
48. Policy # or self-insured certificate #	City Minneapolis	State MN Zip Code 55440-9416
49. Insurer FEIN 41-1459789	50. Date insurer received notice	53. CA FEIN 41-1459789 / 54. Claim #

MN FR01 (09/02) Copies to: Insurer, Employer, Employee, and Workers' Compensation Division (if no insurer)