INDIANA WORKER'S COMPENSATION
FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R9 / 3-01)

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction Claim Number	Process Date

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Social Security Number	Date of Birth	Sex ☐ Male ☐ Female ☐ Unknown	Occupation / Job Title			NCCI Class Code
Name (Last, First, Middle)		Marital Status ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown	Date hired	State of hire		Employee Status
Address (Number and street, city, state, ZIP code)			Hrs / Day	Days / Wk	Avg. Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued
			Wage $ Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other			
Telephone number (including area code)		Number of dependents				

EMPLOYER INFORMATION

Name of employer	Employer ID #	SIC Code	Insured report number
Address of employer (number and street, City, State, ZIP code)	Location number	Employer's location address (if different)	
	Telephone number		
	Carrier/ Administrator claim number	Report purpose code	
Actual location of accident / exposure (if not on employer's premises)			

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate ☐ Self Insurance
Address of claims administrator (number and street, city, state, ZIP code)	☐ Insurance Carrier ☐ Third Party Admin.	Policy / Self-insured number
Telephone number		Policy period From To
Name of agent	Code number	

OCCURRENCE / TREATMENT INFORMATION

Date of Inj. / Exp.	Time of occurrence ☐ AM ☐ PM	Date employer notified	Type of injury / exposure	Type code
Last work date	Time workday began	Date disability began	Part of body	Part code
RTW date	Date of death	Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No	Name of contact	Telephone number
Department or location where accident / exposure occurred		All equipment, materials, or chemicals involved in accident		
Specific activity engaged in during accident / exposure		Work process employee engaged in during accident / exposure		
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.				Cause of injury code

Name of physician / health care provider			INITIAL TREATMENT ☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor: Clinic / Hospital ☐ Emergency Care ☐ Hospitalized > 24 Hours ☐ Future Major Medical / Lost Time Anticipated
Name of witness	Telephone number	Date administrator notified	
Date prepared	Name of preparer	Title	Telephone number

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).