



FIRST REPORT OF INJURY

SFN 2828 (12/2010)

PLEASE PRINT OR TYPE USING BLACK OR BLUE INK AND RETURN TO WSI. Please see reverse side for Fraud Warning and other information.

SECTION 1 Completion of this section is required	Claim Number	Worker's Name	Social Security Number*	Injury Date	Time of Injury <input type="checkbox"/> AM <input type="checkbox"/> PM	Birth Date	
	Worker's Mailing Address					Sex <input type="checkbox"/> F <input type="checkbox"/> M	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
	City			State	Zip	Worker's Home/Cell Phone Number	
	Body Part Injured (Example: Left 2 nd /middle finger, right shoulder, left ankle.)			What was the nature of the injury or illness? (Example: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.)			
	Tell us how the injury occurred and what the worker was doing before the incident (give details). (Example: "Worker was driving lift truck with pallet of boxes when the truck tipped, pinning driver's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry.")						
	Name of Treating Doctor(s)		Clinic/Hospital		E. R. Visit <input type="checkbox"/> Yes <input type="checkbox"/> No	Overnight Stay <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of First Treatment <input type="checkbox"/> N/A
	Address			City	State	Zip	Doctor's Phone Number
	Employer's Name			What is the worker's occupation? (job title or duties)			
	Employer's Address			City	State	Zip	Employer's Phone Number
	If job site, list location - (city, county, state, and zip)		Employer's Premises Job Site <input type="checkbox"/>	Time Worker Began Shift <input type="checkbox"/> AM <input type="checkbox"/> PM	When did worker last work in ND?		Date Hired

SECTION 2 Worker Completion	Date employer notified and person you notified:			Have you had prior problems or injuries to that part of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Witness(es) to the Injury		Address of Witness(es)		Has or will the incident cause you to miss five or more days of work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including records pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS related illness. I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.						
	Worker's Signature			Date Signed	In addition to myself, I authorize WSI to release information on my claim to: (please print)		
				First Name	Last Name	Relationship	

SECTION 3 Medical Provider Completion	Type of Injury (fracture, bruise, cut, etc.)					Date of First Treatment	
	Has the incident caused the worker to miss five or more days of work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Diagnosis condition based upon objective medical findings: Diagnosis code:				
	Has the worker had any prior problems or injuries to that part of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details.						
	Date worker may return to work: <input type="checkbox"/> Without work restrictions <input type="checkbox"/> With the following restrictions (list)						
	Please complete the Physical Lifting Demand Level below – see guide on reverse side.						
	<input type="checkbox"/> Sedentary	10 lbs	<input type="checkbox"/> Light	20 lbs	<input type="checkbox"/> Medium	50 lbs	<input type="checkbox"/> Heavy
Other instructions and/or limitations including prescribed medications or PT order:				Prognosis and anticipated length of medical treatment:			
The above restrictions are in effect until:				Re-evaluation date:		Time:	
Physician's Signature				Date Signed	Physician's Federal Tax ID No.		

SECTION 4 Employer Completion	Employer Account Number	Worker's Rate Class	Causation Code (See reverse)	OSHA Log Number (See reverse)	Has the incident caused the worker to miss five or more days of work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Is worker a corp. officer, owner, partner, spouse or child under age 22? <input type="checkbox"/> Yes <input type="checkbox"/> No		Worker Status: <input type="checkbox"/> Full Time; <input type="checkbox"/> Part Time; <input type="checkbox"/> Seasonal; <input type="checkbox"/> Temporary		First day worker lost wages due to work injury: <input type="checkbox"/> N/A		
	Hourly Rate \$	Hours Worked Per Week	Gross Earnings YTD \$ From to		Job description submitted or attached? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Has the worker had any prior problems or injuries to that part of the body <input type="checkbox"/> Yes <input type="checkbox"/> No					Date employer notified and person notified	
	Do you have a Designated Medical Provider (DMP)? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, did the worker opt out? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date of Death (If applicable)	
	If you question this claim, state reason (continue on back) or attach additional information.						
Employer's Signature			Title	Date Signed			

* In compliance with the Federal Privacy Act of 1974, disclosure of the social security number on this form is mandatory pursuant to N.D.C.C. 65-05-02. The social security number is used for identification and verification purposes. Failure to provide this information may result in a delay in processing your request.

Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for workers' compensation benefits will forfeit any future benefits and may be guilty of a felony which is punishable by imprisonment, substantial fines, or both. These criminal penalties are applicable to all persons dealing with the Fund, including injured workers, employers, medical providers, and attorneys.

To report an instance of fraud, contact the ND Fraud and Safety Hotline at 1-800-777-5033. Additional information:

For medical provider use:

Physical Demand Level	<u>Occasional (0-3 Hours)</u>	<u>Frequent (3-6 Hours)</u>	<u>Constant (6-8 Hours)</u>
Sedentary	10 lbs.	Negligible	Negligible
Light	20 lbs.	10 lbs. and/or Walk/Stand/Push/Pull of Arm/Leg controls	Negligible and/or Push/Pull of Arm/Leg controls while seated.
Medium	50 lbs.	20 lbs.	10 lbs.
Heavy	70 lbs.	50 lbs.	20 lbs.

For employer use:

Causation Codes:

1. Contact with object and/or equipment
2. Fall to lower level
3. Fall on same level
4. Slip, trip, or loss of balance without fall
5. Overexertion
6. Overexertion lifting
7. Repetitive motion
8. Exposure to harmful substances
9. Transportation accident
10. Fire and/or explosion
11. Assault and/or violent act

For more information regarding the OSHA Log number (OSHA 300 Reference Number), visit <http://www.osha.gov/recordkeeping/index.html>