# FIRST REPORT OF INJURY

CLAIMS DIVISION
SFN 2828 (11/2017)

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Bismarck ND 58506-5585
**Telephone 800-777-5033**
Toll Free Fax 888-786-8695
TTY (hearing impaired) 800-366-6888
Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

## SECTION 1 - *Completion of this section is required*

| | | | |
|---|---|---|---|
| Claim number | Worker's (First name) | (Last name) | Social Security number* |
| Date of birth | Gender ☐ Female ☐ Male | Marital status ☐ Single ☐ Married | Worker's telephone number |
| Worker's physical address (Street address) | | | |
| City | | State | ZIP code |
| Worker's mailing address, if different than physical address (Street address, PO Box number) | | | |
| City | | State | ZIP code |
| Date of injury | Time of injury ☐ AM ☐ PM | Nature of injury or illness (broken left leg, carpal tunnel left wrist, etc.) | |
| Body parts injured (Example: 2nd/middle finger, shoulder, ankle, etc.) ☐ Left ☐ Right ☐ NA | | | |
| How did the injury happen? | | | |
| Has this claim been filed in another state? ☐ Yes ☐ No If yes, which state? | | | |
| Where did the injury happen? (City) | (County) | (State) | |
| Treating doctor's name | | | Date of first treatment ☐ NA |
| Clinic/hospital name (If you have received treatment in more than one location, please provide the name of clinic/hospital, treating doctor(s), address and telephone number of all locations on page two or separate sheet of paper.) | | | |
| Clinic/hospital mailing address (Street address, PO Box number) | | | Clinic/hospital telephone number |
| City | State | | ZIP Code |
| Employer's name | | | Employer's telephone number |
| Employer's mailing address | City | State | ZIP code |
| What is the worker's job? | Date hired (Month) (Year) | | Last day worked in ND prior to injury |

## SECTION 2 – *Worker completion*

| | | |
|---|---|---|
| Date employer notified | Person you notified | Before this injury, have you had any problems, injuries, or treatment to the injured body parts? ☐ Yes ☐ No |
| Have you missed or will you miss 5 or more consecutive days of work due to the injury? **OR** Has a doctor taken you off work for 5 or more consecutive days? ☐ Yes ☐ No | | |
| Witness to the injury (First name) | (Last name) | Telephone number |

## SECTION 3 – *Release of information/fraud warning/signature*

**Release of information**

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 all prior records as well as those pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS-related illness. I authorize healthcare providers to respond to WSI regarding my injury, including request for conclusions and opinions not otherwise contained within existing medical records.

(Continued on page 2)

| Claim number | Worker's (First name) | (Last name) |
|---|---|---|
| | | |

In addition, I authorize any education agency or institution to release to WSI any and all "educational records" as defined by 20 U.S.S 21 Sec. 1232g. This authorization continues while I have any claim open or pending before WSI. WSI is exempt from HIPAA regulations. 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.

**Fraud warning**
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 WSI, including injured workers, employers, medical providers, and attorneys.

**Signature**
By signing this form, I acknowledge that I have read and understand the release of information and fraud warning. I understand that falsifying this claim or making a false statement regarding this claim may be a felony, punishable by substantial fines and imprisonment. I authorize the release of information and agree that statements in this form are true and accurate.

| **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 4 - *Employer completion*

| Employer's account number | Rate class | Is worker a corporate officer, owner, or family member? ☐ Yes ☐ No |
|---|---|---|
| Employer's name | Mailing address (Street address, PO Box number) | |
| City | State | ZIP code |

Has the worker missed or will they miss 5 or more consecutive days of work due to the injury? **OR** Has a doctor taken the worker off work for 5 or more consecutive days? ☐ Yes ☐ No

| Date employer notified | Person notified | Before this injury, are you aware of the worker having any problems, injuries, or treatment to the injured body part? ☐ Yes ☐ No ☐ Unknown |
|---|---|---|

| Do you have a Designated Medical Provider (DMP)? ☐ Yes ☐ No | Did the worker add another medical provider? ☐ Yes ☐ No If yes, which provider? | Do you question this claim? ☐ Yes ☐ No If yes, please explain in section 5. |
|---|---|---|

| **Employer's signature** | **Title** | **Date signed** |
|---|---|---|
| | | |

## SECTION 5 – *Additional information or comments*

* 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.

**To report an instance of fraud, contact the ND Fraud and Safety Hotline at 800-243-3331.**