FIRST REPORT OF INJURY

CLAIMS DIVISION
SFN 2828 (11/2024)

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www.workforcesafety.com

SECTION 1 - *Completion of this section is required*

Claim number	Employee's (First name)	(Last name)	Social Security number*
Date of birth	Gender ☐ Female ☐ Male		Marital status ☐ Single ☐ Married
Employee's telephone number	Employee's cell phone number		Employee's email address
Employee's physical address (Street address)			
City		State	ZIP/Postal code
Employee's mailing address, if different than physical address (Street address, PO Box number)			
City		State	ZIP/Postal 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/province? ☐ Yes ☐ No If yes, which state?			
Where did the injury happen? (City)	(County)	(State)	
Clinic/hospital name			Emergency room visit ☐ Yes ☐ No
Treating doctor's name			Date of first treatment ☐ NA
Clinic/hospital mailing address (Street address, PO Box number)			Clinic/hospital telephone number
City	State		ZIP/Postal code
Employer's name			Employer's telephone number
Employer's mailing address	City	State	ZIP/Postal code
What is the employee's job?	Date hired (Month) (Year)		Last day worked in ND prior to injury

SECTION 2 – *Employee 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.

First Report of Injury continued on page 2. Submit both pages to WSI.

Claim number	Employee'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 employees, 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.

Employee'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 employee a corporate officer, owner, or family member? ☐ Yes ☐ No
Employer's name	Mailing address (Street address, PO Box number)	
City	State	ZIP/Postal code

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

Date employer notified	Person notified	Before this injury, are you aware of the employee 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 employee 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.