Indiana Worker's Compensation
First Report of Employee Injury/Illness

Please Return Completed Form to: 402 W. Washington St, Room W1 96
Indianapolis, IN 46204-2753
(317) 232-3808

FOR WORKER'S COMPENSATION BOARD USE ONLY		
JURISDICTION	JURISDICTION CLAIM NUMBER	PROCESS DATE

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/JOBTITLE	NCCI CLASS CODE

LAST NAME	FIRST	MIDDLE	MARITAL STATUS	DATE HIRED	STATE OF HIRE	EMPLOYEE STATUS
			○ UNMARRIED ○ MARRIED ○ SEPARATED ○ UNKNOWN			

ADDRESS (INCL ZIP)	HRS/DAY	DAYS/WK	AVG WG/WK	PAID DAY OF INJ ☐ SALARY CONT'D ☐

PHONE	# OF DEPENDENTS	WAGE $	PER ○HR ○DA ○WK ○MO ○YR ○OTHER

EMPLOYER INFORMATION

EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP)	EMPLOYER FEDERAL ID#	SIC CODE	INSURED REPORT NUMBER
Wabash College 301 W Wabash Ave Crawfordsville, IN 47933	35-0868202		
	LOCATION #	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
	PHONE# 765-361-6100		
	CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE

Actual Location of Accident/Exposure (if not on employers premises):

CARRIER/CLAIMS ADMINISTRATOR INFORMATION

CLAIMS ADMINISTRATOR (NAME, ADDRESS, PHONE NO)	CARRIER FEDERAL ID#	CHECK IF APPROPRIATE
Accident Fund 232 S Capitol Ave Lansing, MI 48901 PHONE: FAX: 866-814-5595 PH: 866-206-5851	☒ INSURANCE CARRIER ☐ THIRD PARTY ADMIN	☐ SELF INSURANCE POLICY/SELF-INSURED NUMBER WCV6029720 POLICY PERIOD FROM 04/01/07 TO 04/01/08

AGENT NAME: GREGORY & APPEL INSURANCE — CODE NUMBER:

OCCURRENCE/TREATMENT INFORMATION

DATE OF INJ/EXP	TIME OF OCCURRENCE _ M	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	CONTACT NAME	PHONE 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

WITNESSES (NAME, PHONE #) — DATE ADMINISTRATOR NOTIFIED

DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER

INITIAL TREATMENT
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR: BY EMPLOYER
- ☐ MINOR: CLINIC/HOSP
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED >24 HRS
- ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13) STATE FORM 34401 (R8 2/96)