

Minnesota Department of Labor and Industry
Electronic Filing of First Report of Injury Implementation Guide

Appendix A First report of injury form

MN Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

First Report of Injury

See Instructions on Reverse Side



PRINT IN INK or TYPE
ENTER DATES IN MM/DD/YYYY FORMAT

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY # DN0042/DN0154 DN0270		2. OSHA case #		3. Time employee began work on date of injury <input type="checkbox"/> am <input type="checkbox"/> pm	
4. DATE OF CLAIMED INJURY DN0031		5. Time of injury <input type="checkbox"/> am <input type="checkbox"/> pm DN0032		6. Date of death DN0057	
7. EMPLOYEE Name (last, suffix, first, middle) DN0043, DN0255, DN0044, DN0045		8. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F		9. Marital status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Unmarried	
10. Home address DN0046 DN0047		11. Home phone # DN0051		12. Date of birth DN0052	
City State Zip Code DN0048 DN0049 DN0050 DN0155		14. Occupation DN0060		15. Regular department DN0027	
17. Average weekly wage DN0062/DN0063		18. Rate per hour DN0062 / DN0063		19. Hours per day	
20. Days per week DN0064		Normal work schedule S M T W T F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		21. Employment status (check all that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer	
22. Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was. Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry." DN0038 DN0204/DN0205 DN0058					
23. What was the injury or illness (include the part(s) of body)? Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist. DN0035 DN0036			24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. DN0037		
25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No DN0249		26. First date of any lost time DN0056		27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> No lost time on DOI DN0066	
Name and address of the place of the occurrence DN0119/DN0120 DN0122 DN0121 DN0123 DN0033 DN0280		28. Date employer notified of injury DN0040		29. Date employer notified of lost time DN0281 DN0228 DN0224	
		30. Return to work date DN0068/DN0189		31. RTW same employer <input type="checkbox"/> Yes <input type="checkbox"/> No	
				32. RTW with restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No	
33. Treating physician (name)		34. Extent of medical treatment (check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Minor on-site by employer's medical staff <input type="checkbox"/> Minor clinic/hospital <input type="checkbox"/> Emergency room <input type="checkbox"/> Hospitalization more than 24 hours <input type="checkbox"/> Future major medical anticipated DN0039			
35. Certified Managed Care Organization (if any) DN0208					
36. EMPLOYER Legal name DN0018 (but use DBA name)			37. EMPLOYER DBA name (if different)		
38. Mailing address DN0168 DN0169			39. Employer FEIN DN0016		40. Unemployment ID # DN0329
City State Zip Code DN0165 DN0170 DN0167 DN0166			41. Employer's contact name and phone # DN0160 DN0159		
42. Physical address (if different) DN0019 DN0020			43. Witness (name and phone) - if more than 1 attach a separate sheet DN0238 DN0237		
City State Zip Code DN0021 DN0022 DN0023 DN0164			44. NAICS code DN0025		45. Date form completed
46. INSURER name DN0007			51. CLAIMS ADMIN COMPANY (CA) name (check one) DN0188 <input type="checkbox"/> Insurer <input type="checkbox"/> TPA		
47. Insured legal name and FEIN DN0017 DN0314			52. CA address DN0010 DN0011		
48. Policy # (including effective dates) or self-insured certificate # DN0028 DN0029 DN0030			City State Zip Code DN0012 DN0013 DN0014		
49. Insurer FEIN DN0006/DN0292		50. Date insurer received notice DN0041		53. CA FEIN DN0187	
				54. CA claim # DN0015	
55. To be completed by the CA:		Claim type code: DN0074	Type of loss code: DN0290	Late reason code: DN0077	Salary paid in lieu of comp? DN0273
					Death result of injury? DN00146

MN FR01 (2/13)

Employer: Send copies to Insurer (or Workers' Compensation Division if no insurer), employee, and employee's union (if applicable)