FORM 1

ALL COPIES OF THIS FIRST REPORT MUST BE TYPED OR PRINTED

Industrial Accident Board
Office of Workers' Compensation
4425 N. Market Street; 3rd Floor
Wilmington, DE 19802
Telephone (302) 761-8200

STATE OF DELAWARE
EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

I.A.B. FILE No. _____

EMPLOYER'S F.E.I.N. _____

ALL INFORMATION IS REQUIRED, unless inapplicable where "if applicable" is noted.

EMPLOYEE

1. FIRST: MIDDLE: LAST:		2. EMPLOYEE SOCIAL SECURITY No.:	
3. ADDRESS – INCLUDE COUNTY AND ZIP CODE:		4. MALE: ☐ FEMALE: ☐	5. EMPLOYEE PHONE No. (WITH AREA CODE):
6. DATE OF BIRTH:	7. AGE: 8. WAGE:	9. WEEKLY HOURS WORKED:	
10. OCCUPATION (REGULAR):	11. DEPARTMENT OR DIVISION REGULARLY EMPLOYED:	12. HOW LONG EMPLOYED:	

EMPLOYER

13. EMPLOYER:	14. PERSON MAKING OUT THIS REPORT:
15. ADDRESS – INCLUDE COUNTY AND ZIP CODE:	16. EMPLOYER PHONE No. (INCLUDE AREA CODE):
17. MAILING ADDRESS – IF DIFFERENT THAN ABOVE:	18. NATURE OF BUSINESS – TYPE OF MFG., TRADE, CONSTRUCTION, SERVICE, ETC.:

INSURANCE

19. WORKERS' COMPENSATION INSURANCE CARRIER:	20. WORKERS' COMP. INS. CARRIER PHONE No. (INCLUDE AREA CODE):
21. WORKERS' COMPENSATION INSURANCE CARRIER ADDRESS:	22. POLICY NUMBER / CARRIER CASE NUMBER:
23. THIRD PARTY ADMINISTRATOR (T.P.A.), IF APPLICABLE:	24. T.P.A. ADDRESS – INCLUDE CITY, STATE AND ZIP CODE:

DATES

25. DATE OF REPORT:	26. DATE AND TIME OF INJURY: ☐ AM ☐ PM	27. NORMAL STARTING TIME: ☐ AM ☐ PM	28. DATE IF EMPLOYEE BACK TO WORK:	29. AT SAME WAGE? YES ☐ NO ☐
30. IF FATAL INJURY, GIVE DATE OF DEATH:	31. DATE EMPLOYER KNEW OF INJURY:	32. DATE DISABILITY BEGAN:	33. LAST FULL DAY PAID DATE:	

INJURY OR DISEASE

34. DESCRIBE THE INJURY / ILLNESS AND PART OF BODY AFFECTED:

35. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED:

OCCURRENCE

36. LIST THE EQUIPMENT, MATERIALS AND CHEMICALS EMPLOYEE USED WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE:

37. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, E.G. LIFTING A PATIENT:

38. DESCRIBE HOW THE INJURY / ILLNESS OCCURRED:

39. NAME OF PHYSICIAN (IF APPLICABLE):	40. PHYSICIAN'S ADDRESS:
41. HOSPITAL (IF APPLICABLE):	42. HOSPITAL ADDRESS:

DISTRIBUTION OF THIS REPORT (1 original and 3 copies)

1. ORIGINAL TO INDUSTRIAL ACCIDENT BOARD (USE THE ADDRESS AT THE TOP LEFT OF THIS FORM).
2. COPY MUST BE SENT TO EMPLOYER'S WORKERS' COMPENSATION INSURANCE CARRIER.
3. EMPLOYER'S COPY – RETAIN AS RECORD.
4. EMPLOYEE'S COPY.

_____ SIGNATURE OF PERSON IN 14 ABOVE

_____ OFFICIAL POSITION OF PERSON IN 14 ABOVE