

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: <input type="checkbox"/> FEMALE: <input type="checkbox"/>	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: <input type="checkbox"/> AM <input type="checkbox"/> PM		27. NORMAL STARTING TIME: <input type="checkbox"/> AM <input type="checkbox"/> PM	28. DATE IF EMPLOYEE BACK TO WORK:	29. AT SAME WAGE? YES <input type="checkbox"/> NO <input type="checkbox"/>
	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