FORM 1

ALL COPIES OF THIS FIRST REPORT MUST BE TYPED OR PRINTED

INDUSTRIAL ACCIDENT BOARD
4425 N. Market Street; 3rd Fl.
Wilmington, DE 19802
Telephone (302) 761-8200
Facsimile (302) 736-9170

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