

First Report of Injury

Please PRINT or TYPE your responses.
 Enter dates in MM/DD/YY format.



Do Not Use This Space

1. EMPLOYEE SOCIAL SECURITY #		2. OSHA Case#	
3. DATE OF CLAIMED INJURY		4. Time of injury <input type="checkbox"/> AM <input type="checkbox"/> PM	
		5. Time employee began work on date of injury <input type="checkbox"/> AM <input type="checkbox"/> PM	
6. EMPLOYEE Name (last, first, middle)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8 Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried
9. Home address		10. Home Phone #	11. Date of Birth
City	State	Zip Code	12. Occupation
		13. Dept/Location Code	14. Date Hired
15. Average weekly wage \$	16. Rate per hour \$	17. Hours per day	18. Days per week
		19 Employment Status <input type="checkbox"/> Full-time <input type="checkbox"/> Seasonal	<input type="checkbox"/> Part-time <input type="checkbox"/> Volunteer
20. Weekly value of:	Meals \$	Lodging \$	2 nd Income \$
		21. Apprentice <input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Tell us how the injury or illness occurred and what the employee was doing before the incident. (give details). Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under the drive shaft." "Worker developed soreness in left wrist over time from daily computer entry.			
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.		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.	
25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, indicate name and address of place of occurrence.		26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI
		28. Date employer notified of injury	29. Date employer notified of lost time
		30. Return to work date	31. Date of death
32. TREATING PHYSICIAN (name, address, and phone)		33. HOSPITAL/CLINIC (name and address) (if any)	34. Emergency Room <input type="checkbox"/> Yes <input type="checkbox"/> No
			35. Overnight in-patient <input type="checkbox"/> Yes <input type="checkbox"/> No
36. EMPLOYER Legal name		37. EMPLOYER DBA name (if different)	
38. Mailing address		39. Employer FEIN	40. Unemployment ID#
City	State	Zip Code	41. Employer's contact name and phone #
42. Physical address (if different)		43. Witness (name and phone)	
City	State	Zip Code	44. NAICS code
		45. Date form completed	
46. INSURER name State of MN – Dept of Employee Relations		51. CLAIMS ADJUSTER (CA) name (check one) <input type="checkbox"/> Insurer <input type="checkbox"/> TPA	
47. Insured legal name State of Minnesota		52. CA address P.O. Box 64081	
48. Policy # or self-insured certificate #		City St. Paul	State MN
		Zip Code 55164-0081	
49. Insurer FEIN 41-6007162	50. Date insurer received notice	53. CA Phone #	54. Claim #

MN FR01 (09/02) Copies to: Insurer (DOER), Employer (Agency) and Employee.

IMPORTANT NOTICE

Whenever you become aware of any work-related injury or illness that requires medical care or lost time from work, you must report the injury or illness to DOER as soon as possible. The filing of this report is not an admission of liability. If your agency has access to SEMA4, this report must be entered into SEMA4. (See the Workers' Compensation System User Guide Appendix A for Instructions on how to enter an FRI into SEMA4). If your agency does not have SEMA4, you must send your completed forms to DOER. The prompt filing of this report with DOER and the Department of Labor and Industry is required by law. The State of Minnesota is self-insured so there are 14 days to have the claim filed with the Department of Labor and Industry before becoming subject to penalties. You should file this report immediately with DOER using SEMA4 or if needed send the forms to DOER. This will allow DOER as much time as possible to investigate the claim based on the information you completed when filing the claim. Even if the claim is questionable, it is important that you report it promptly. If you question the claim, enter the information in the appropriate screen when filling in the claim information. Each case should also be recorded on your OSHA 300 log, if necessary. This form contains all items required by OSHA form 301.

GENERAL INSTRUCTION TO THE EMPLOYER

Death or serious injury arising from employment must be reported to the Department of Employee Relations within 48 hours of the occurrence. You may initially report by telephone (651) 259-3637, or facsimile (651) 297-5471, or personal notice within 48 hours, but the filing of this report in SEMA4 must follow the notice with DOER within seven days of the occurrence. If a reported injury subsequently results in death, a report of death must be made to DOER within 48 hours of when you are notified of the death.

If the employee cannot work for a period of more than three days, the workers' compensation claim must be entered into SEMA4 and sent to DOER electronically within ten days. DOER will forward any necessary forms to the Department of Labor and Industry.

Please type or print legibly. **The employee's immediate supervisor should complete this form.** It is absolutely essential that you fill in all the information you can. Each piece of information is needed to determine liability and entitlement to benefits. Failure to complete the form may result in delayed processing and possible penalties. Provide copies to DOER and your injured worker. If the claim results in the employee's inability to work for a period of more than three days, send a copy of this report to the employee's local union office. Fill in all the information you can, except items 46-54.

Form Instructions Employee Information

Item 1: Self-explanatory. **Required.**

Item 2: OSHA Case #. Fill in the case number from the OSHA 300 log. If sent via SEMA4 by your agency, the OSHA case number will be SEMA4's incident #.

Items 3 - 7: Self-explanatory. **Required information** on injured employee and the date of claimed injury. If the actual date is unknown due to continuous nature of injury, use date employee became aware there might have been a work-related injury.

Item 8: Check the appropriate box for Marital Status.

Item 9: Self-explanatory. **Required information** on injured employee.

Item 10: **Required.** Enter the employee's home phone number – need area code/telephone number.

Item 11: **Required.** Enter the date of birth of the injured employee.

Item 12: Enter the employee's classification code (6 digit number) and the employee's classification title. Your agency's personnel office has this information.

Item 13: **Required.** Enter the 6 digit code identifying the location where the injury occurred. Your agency's personnel office has this information.

Item 14: **Required.** Enter the date the employee was hired by the State of Minnesota (not agency).

Wage Information

Note: Wage information is required. Employee cannot be paid without completed information.

Item 15: To compute the average wage/week, multiply the number of work hours per day by the employee's hourly rate. Then multiply the result by the number of days per week. If the employee does not work the same number of hours each week or received differential or overtime pay in at least half of the 26-week time period preceding the injury, a 26-week wage statement must be attached.

Item 16: Enter the employee's current hourly rate.

Item 17: Enter the number of hours worked per day.

Item 18: Enter the number of days worked per week.

Item 19: Check the appropriate employment status.

Item 20: Record employee's additional income if appropriate such as second employment wages.

Item 21: Check "Yes" if the employee was in an apprenticeship program at the time of the injury.

Occurrence

Item 22: **Required.** Be as specific as possible in describing the events causing the injury. See examples on form, box 22.

Item 23: **Required.** Describe the body part (i.e., right hand, left leg, neck, shoulder, etc.) affected or injured and nature of the injury (i.e., cut, sprain, burn, etc.).

Item 24: **Required.** Name of the object (i.e., person, vehicle, machine, substance, etc.) that was involved in the injury/illness.

Item 25: Place where the accident occurred. Check appropriate box to answer whether or not the claimed injury occurred on or off the employer's premises.

Item 26: **Required if lost time.** Fill in the first day the employee lost time from work, even if you paid the employee for the full day.

Item 27: Check the appropriate box to indicate whether you paid for that lost time.

Item 28: **Required.** Be sure to fill in the date you **first** became aware of the injury or illness. This is used to determine whether the form is filed on time. You have seven (7) calendar days from the date you became aware of the injury to report to and be received by the Department of Employee Relations, Employee Insurance Division, Workers' Compensation Program.

Item 29: **Required if lost time.** Record the date you were notified that the employee lost time from work. This item will be completed by the Department of Employee Relations upon notification by the agency that an employee is losing time after the First Report of Injury has previously been submitted by the agency.

Item 30: If the employee has not returned to work by the time you are filing this form, leave the box blank and call the Workers' Compensation Program when the employee returns to work. If the employee has returned to work, indicate the date on the form. Be sure to notify the Workers' Compensation Program immediately if the injured employee starts missing time due to this injury.

Item 31: A death must be reported to the Department of Employee Relations within 48 hours of an employee's death.

Item 32: Physician's name that treated the employee for his/her injury or illness.

Item 33: Name of the hospital or clinic who provided medical treatment to the employee.

Item 34: **Required.** Check the appropriate box whether there was an Emergency Room visit.

Item 35: **Required.** Check the appropriate box whether there was an Overnight in patient stay.

Employer

Item 36: **Required.** Enter the agency name.

Item 37: Leave blank.

Item 38: Enter the address of the employer.

Item 39, 40 & 44: Do not fill in. The Department of Employee Relations will add this information.

Item 41: **Required.** Enter the name of your agency's representative, title and telephone number. This should be your agency's director, personnel director or workers' compensation coordinator.

Item 42: Leave blank.

Item 43: Name (first and last) of any witness (es) to the accident and their telephone number.

Item 45: **Required.** Date form is completed by the agency. If sent via SEMA4 by your agency, this will be SEMA4's send date.

Insurance

Items 46 – 54: Do not fill in. The Department of Employee Relations will add this information.

SEND REPORT IMMEDIATELY TO YOUR AGENCY REPRESENTATIVE – DO NOT WAIT FOR DOCTOR'S REPORT

DOER will send a copy of the final FRI to the agency and the employee.

This material can be made available in different formats, such as large print, Braille or on a tape. To request an alternate format, call (651) 259-3800 or Fax (651) 297-5471 or TDD (651) 282-2699.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.