

## MWCC – WORKERS’ COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
EMPLOYER'S LOCATION ADDRESS		LOCATION #		
SIC CODE	EMPLOYER FEIN	PHONE #		

### CARRIER/CLAIMS ADMINISTRATION

CARRIER (NAME, ADDRESS & PHONE NO) MS Municipal W/C Group 600 East Amite Street, Suite 200 Jackson, MS 39201		POLICY PERIOD  TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) MS Municipal W/C Group Phone # 800-898-1032 Fax # 601-355-8584	
CARRIER FEIN		POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN	
AGENT NAME & CODE NUMBER				

### EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX	MARITAL STATUS		OCCUPATION/JOB TITLE
		<input type="checkbox"/> MALE (M) <input type="checkbox"/> FEMALE (F) <input type="checkbox"/> UNKNOWN (U)	<input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U) <input type="checkbox"/> MARRIED (M) <input type="checkbox"/> SEPARATED (S) <input type="checkbox"/> UNKNOWN (K)	EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS	NCCI CLASS CODE			
RATE PER:	DAY WEEK	MONTH OTHER:	# DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?	YES NO YES NO

### OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	AM PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM PM	LAST WORK DAY	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE		
COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGURDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?	YES NO YES NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)	<b>INITIAL TREATMENT</b> NO MEDICAL TREATMENT(0) <input type="checkbox"/> MINOR: BY EMPLOYER (1) <input type="checkbox"/> MINOR CLINIC/HOPITAL (2) <input type="checkbox"/> EMERGENCY CARE (3) <input type="checkbox"/> HOSPITALIZED > 24 HRS (4) <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) <input type="checkbox"/>
WITNESSES (NAME & PHONE #)			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARED'S NAME & TITLE	PHONE NUMBER