

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		
DEPARTMENT:		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
<input type="checkbox"/> CHECK IF APPROPRIATE SELF INSURANCE			
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	
		<input type="checkbox"/> MALE (M)	<input type="checkbox"/> FEMALE (F)	<input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U)	<input type="checkbox"/> MARRIED (M)
PHONE		# OF DEPENDENTS	<input type="checkbox"/> SEPARATED (S)	EMPLOYMENT STATUS (FT, PT, VOL)	
			<input type="checkbox"/> UNKNOWN (K)	NCCI CLASS CODE	
RATE PER:	DAY WEEK	MONTH OTHER:	# DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY?	YES <input type="checkbox"/> NO <input type="checkbox"/>
				DID SALARY CONTINUE?	YES <input type="checkbox"/> NO <input type="checkbox"/>

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DAY	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
SUPERVISOR 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT
WITNESSES (NAME & PHONE NUMBER)				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"/>
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARED'S NAME & TITLE	PHONE NUMBER	

SEE BACK FOR INSTRUCTIONS
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