EMPLOYER'S FIRST REPORT OF INJURY

Completion Tips

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE
FAX COMPLETED FORM TO (205) 991-7978

Mandatory Employer's Federal Tax I.D. Number

Your member number which may begin with 600-

CLAIM REFERENCE

FEDERAL TAX ID NUMBER (REQUIRED):	INSURED POLICY NUMBER:
63-1111111	600-2015-12345-00

EMPLOYER

Employer Business Name: **Blooming Tulips** Physical Address 1: **100 Bloomington Trail** Physical Address 2: City: **Employertown** State: **AL** Zip: **12345**	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS: Mailing Address 1: **PO Box 1234** Mailing Address 2: City: **Employertown** State: **AL** Zip: **12345**

Provide FULL name & last known address

INSURER / FILING OFFICE

Insurer Name: *Sheffield Risk Management* Mailing Address: *900 Corporate Drive* City: *Birmingham* State: *AL* Zip: *35242*	Filing Office Phone Number: *(205) 991-7552* Filing Office Fax Number: *(205) 991-7978*

EMPLOYEE / WAGES

First Name: **Summer** Middle Name: **Bree** Last Name: **Sunshine** Last Name Suffix:	EMPLOYEE SSN: **111-22-3333** DATE OF BIRTH: **09/01/1990**	*Mandatory*
Mailing Address 1: **1234 Dirt Drive** Mailing Address 2: City: **Employertown** State: **AL** Zip: **12345** 39. Phone:205/###-####	Gender: Male ☐ Female **X**	Date of Hire: **4/15/14**
Marital Status: Unmarried (Single/Divorced/Widowed) ☐ Married ☐ Separated ☐ Unknown **X**		Nbr of Dependents: **0**
Occupation Description: **Fertilizer Specialist**		# of Days Worked Per Week: **5**
Wages:**$546.00** # of Hours Worked Per Week: **37.50** Hourly☐ Daily☐ Weekly **X** Bi-weekly☐ Monthly☐	Received Full Pay For Day of Injury? Yes **X** No ☐ Did Salary Continue After Incident? Yes **X** No ☐	

Where did accident occur?

Date doctor took employee out of work

INJURY / TREATMENT

DATE OF INJURY:	Time of Injury:	Time Employee Began Work:	Date Disability Began:	Date of Death:
1/14/14	**12:59** a.m. ☐ p.m. **X**	**8:00** a.m. **X** p.m. ☐	**1/15/14**	

PLACE OF ACCIDENT, INJURY, OR EXPOSURE:	Injury Occurred on Employer's Premises?
Site Address: **100 Bloomington Trail** City: **Employertown** State: **AL** Zip: **12345** County: **Sinclair**	Yes **X** No ☐ **Date Employer Notified: 1/14/14**

Provide complete details regarding how accident occurred including specific body parts.

Has Employee returned back to work? Date?

DESCRIBE IN DETAIL WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT, HOW THE INJURY OCCURRED AND BODY PARTS AFFECTED:

Summer was mixing fertilizer, preparing to spray plants when some got into her right eye, causing watering and redness.

Initial Treatment:
No Medical Treatment☐ First Aid By Employer☐ Minor Clinic **X** Emergency Room☐ Hospitalized > 24 Hours ☐

Name of Treatment Facility/Physician: **Urgency Clinic**
Address: **1 Medical Urgency Drive** City: **Ourtown** State: **AL** Zip: **12346**

Has Injured Returned to Work? Yes **X** No ☐	Date Injured Returned to Work: **1/16/14**

Thorough form completion by a supervisor, manager, or H.R. person.

OTHER

Date Prepared:	Preparer's First & Last Name: Title:	
1/16/14	**Ray Bloomington, Owner**	Preparer's Phone: **205/###-####** Preparer's Fax: **205/###-####** Preparer's E-mail: **Bloomingtulips@internet.com**

Please provide email address if possible.

THE EMPLOYER'S FIRST REPORT OF INJURY FORM SHOULD BE COMPLETED AS SOON AS POSSIBLE. THERE ARE 3 DIFFERENT WAYS TO SUBMIT THIS FORM…

1. **FAX** (205) 991-7978
2. **EMAIL** NEWCLAIM@SHEFFIELDRISK.COM
3. **MAIL** SHEFFIELD RISK MANAGEMENT, 900 CORPORATE DRIVE, BIRMINGHAM, AL 35242