**STATE OF ALABAMA**

**EMPLOYER’S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE**

**EMAIL COMPLETED FORM TO** **NEWCLAIM@SHEFFIELDRISK.COM**

**OR FAX TO 205-991-7978**

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| **CLAIM REFERENCE** |
| **FEDERAL TAX ID NUMBER (REQUIRED):**  | INSURED POLICY NUMBER:  |
| **EMPLOYER** |
| Employer Business Name:     Physical Address 1:       Physical Address 2:       City:       State:       Zip:        | ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS:Mailing Address 1:       Mailing Address 2:       City:       State:       Zip:       |
| **INSURER / FILING OFFICE** |
| Insurer Name: *Sheffield Risk Management*Mailing Address: 900 Cor*porate Drive*City: *Birmingham* State: *AL* Zip: *35242* | Filing Office Phone Number: *(205) 991-7552*Filing Office Fax Number: *(205) 991-7978*Email report to: newclaim@sheffieldrisk.com  |
| **EMPLOYEE / WAGES** |
| First Name:     Middle Name:     Last Name:     Last Name Suffix:      | **EMPLOYEE SSN**:       **DATE OF BIRTH**:       |
| Mailing Address 1:       Mailing Address 2:       City:       State:      Zip:       39. Phone:        | Gender:Male [ ] Female [ ]   | **Date of Hire:**        |
| Marital Status:Single [ ]  Divorced [ ]  Widowed [ ]  Unmarried [ ]  Married [ ]  Separated [ ]  Unknown [ ]  | Nbr of Dependents:        |
| Occupation Description:       | **#** of Days Worked Per Week:        |
| Wages: $       # of Hours Worked Per Week:      Hourly [ ]  Daily [ ]  Weekly [ ]  Bi-weekly [ ]  Monthly [ ]   | Received Full Pay For Day of Injury? Yes [ ]  No [ ]  Did Salary Continue After Incident? Yes [ ]  No [ ]   |
| **INJURY / TREATMENT** |
| **DATE OF INJURY:**       | Time of Injury:       a.m. [ ]  p.m. [ ]  unk [ ]   | Time Employee Began Work:       a.m. [ ]  p.m. [ ]   | Date Disability Began:        | Date of Death:      |
| PLACE OF ACCIDENT, INJURY, OR EXPOSURE:Site Address:       City:       State:       Zip:       County:        | Injury Occurred on Employer’s Premises? Yes [ ]  No [ ]   **Date Employer Notified:**       |
| DESCRIBE IN DETAIL WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT, HOW THE INJURY OCCURRED AND BODY PARTS AFFECTED:               |
| Initial Treatment:No Medical Treatment [ ]  First Aid By Employer [ ]  Minor Clinic [ ]  Emergency Room [ ]  Hospitalized > 24 Hours [ ]   |
| Name of Treatment Facility/Physician:            Address:       City:       State:       Zip:        |
| **Has Injured Returned to Work?**  Yes [ ]  No [ ]  | **Date Injured Returned to Work:**       |
| **OTHER** |
| Date Prepared:        | Preparer’s First Name: Last Name: Title:                | Preparer’s Phone:      Preparer’s Fax:      Preparer’s E-mail:        |

 8/17/18