**STATE OF ALABAMA**

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

**EMAIL COMPLETED FORM TO** [**NEWCLAIM@SHEFFIELDRISK.COM**](mailto: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