INDIANA WORKER'S COMPENSATION  
FIRST REPORT OF EMPLOYEE INJURY, ILLNESS  
State Form 34401 (R9 / 3-01)  

Please return completed form electronically by an approved EDI process.

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

### EMPLOYEE INFORMATION

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Occupation / Job Title</th>
<th>IC class code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

Name (last, first, middle)  
Marital status  
Date hired  
State of hire  
Employee status  
Hrs / Day  
Days / Wk  
Avg Wk / Wk  
Paid Day of Injury  
Salary Continued  
Wage  
Per Hour  
Day  Week  Month  

### EMPLOYER INFORMATION

<table>
<thead>
<tr>
<th>Name of employer</th>
<th>Employer ID#</th>
<th>SIC code</th>
<th>Insured report number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Location number  
Employer's location address (if different)  
Telephone number  
Carrier / Administration claim number  
Report purpose code  

Actual location of accident / exposure (if not on employer's premises)

### CARRIER / CLAIMS ADMINISTRATOR INFORMATION

<table>
<thead>
<tr>
<th>Name of claims administrator</th>
<th>Carrier federal ID number</th>
<th>Check if appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Insurance Carrier  
Third PArty Admin.  
Policy / Self-insured number  
Policy period FROM  
TO N/A  

Name of agent  
Code number  

### OCCURRENCE / TREATMENT INFORMATION

<table>
<thead>
<tr>
<th>Date of Inj. / Exp.</th>
<th>Time of occurrence</th>
<th>Date employer notified</th>
<th>Type of injury / exposure</th>
<th>Type code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AM    PM</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

Last work date  
Time workday began  
Date disability began  
Part of body  

Injury / Exposure occurred on employer's premises?  
YES  
NO  

Name of contact  
Telephone number  

Department or location where accident / exposure occurred  
All equipment, materials, or chemicals  
N/A  

Specific activity engaged in during accident / exposure  
Work process employee engaged in during accident / exposure  
N/A  

How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.  

Name of physician / health care provider  

### INITIAL TREATMENT

<table>
<thead>
<tr>
<th>Name of witness</th>
<th>Telephone number</th>
<th>Date administrator notified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date prepared  
Name of preparer  
Title  
Telephone number  

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).