REPORTING WORKERS' COMPENSATION CLAIMS
DELAWARE

You should report workers' compensation claims to us as soon as possible after a work-related injury occurs. Delaware insurance laws require that a report of injury must be received at the Delaware Office of Workers' Compensation within **10 days** of the date that you, as the employer, become aware of the work-related injury or illness.

NOTE: IF THIS ACCIDENT HAS RESULTED IN THE EMPLOYEE'S DEATH YOU MUST NOTIFY US IMMEDIATELY.

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INSTRUCTIONS FOR PREPARING DELAWARE DOC. No. 60-07-02-11-12-01

We understand the Delaware First Report of Occupational Injury or Disease may appear confusing. In order to make it easier to complete, we ask that you follow the steps outlined on page 2. We have indicated where information is **not required;** for all other items, complete as many as you can – we will make calls to obtain the rest of the information.

STATE OF DELAWARE
FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

If you are unable to complete all of this form, please **DO NOT** let this keep you from providing us with as much information as you have. The **MOST** important thing is that we receive the basic information **IMMEDIATELY!**

Case or File No.: (NOT REQUIRED)

Complete the following information in the section titled EMPLOYEE:

1. Employee's name, First – Middle – Last
2. Employee's Social Security Number
3. Employee's address
4. through 7. Employee's sex, phone number, date of birth, age
8. Employee's wage (gross wage per year, per day, or per hour)
9. Number hours employee works per week
10. Employee's regular occupation
11. Department or division where employee usually worked
12. How long employee employed?

Complete the following information in the section titled EMPLOYER:

13. Employer name
14. Name of person making out this report **(REQUIRED)**
15. Employer address, **including county and zip code**
16. Employer phone number where person making report can be reached **(REQUIRED)**
17. Employer mailing address, if different than address provided in item number 15
18. Nature of business (mfg., trade, construction, service, etc.)

Complete the following information in the section titled WORKERS' COMPENSATION INSURANCE CARRIER:

19.- 22. This information is on the Declaration Page of the WC Policy
23. Third Party Administrator **(NOT APPLICABLE)**
24. TPA Address **(NOT APPLICABLE)**

Complete the following information in the section titled DATES:

25. Date of report
26. Date and time of injury
27. Employee's normal starting time
28. If the employee came back to work following injury, provide date
29. Did the employee come back to work following injury at the same wage as before injury?
30. If injury was fatal, give date of death
31. What was the date the employer first knew of the injury?
32. Date disability began (date employee was first off from work)
33. Last full day employee was paid

Complete the following information in the section titled INJURY OR DISEASE:

34. Describe the injury/illness and the part of the body affected
35. Specify the department where the incident occurred and the work process involved

Complete the following information in the section titled OCCURRENCE:

36. List the equipment, materials and chemicals the employee was using when the incident occurred
37. Describe the employee's activity at the time of injury or illness
38. Describe how the injury/illness occurred
39. Name of physician, if known **(NOT REQUIRED)**
40. Physician's address, if known **(NOT REQUIRED)**
41. Hospital, if applicable **(NOT REQUIRED)**
42. Hospital address, if applicable