MN Department of Labor and Industry
Workers' Compensation Division
(651) 284-5032 or 1-800-342-5354

First Report of Injury

See Instructions on Reverse Side

Print in ink or type
Enter dates in MM/DD/YYYY format

FRO 1

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm	
4. DATE OF CLAIMED INJURY	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)
7. EMPLOYEE Name (last, suffix, first, middle)		8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried
10. Home address		11. Home phone #	12. Date of birth / 13. Date hired
City State Zip Code		14. Occupation	15. Regular department / 16. Apprentice ☐ Yes ☐ No

17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week	Normal work schedule Sun - Sat (S M T W T F S) ☐ ☐ ☐ ☐ ☐ ☐ ☐	21. Employment status (check all that apply) ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No Name and address of the place of the occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI
	28. Date employer notified of injury	29. Date employer notified of lost time
	30. Return to work date	31. RTW same employer ☐ Yes ☐ No / 32. RTW with restrictions ☐ Yes ☐ No
33. Treating physician (name)	34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated	
35. Certified Managed Care Organization (if any)		

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)	
JACKSON COUNTY CENTRAL SCHOOL DISTRICT #2895	ISD #2895	
38. **Mailing** address	39. Employer FEIN	40. Unemployment ID #
PO BOX 119	411872029	07995194
City State Zip Code	41. Employer's contact name and phone #	
JACKSON MN 56143	EMILY ANDERSON 507 847 3608	
42. **Physical** address (if different)	43. Witness (name and phone) - if more than 1 attach a separate sheet	
1128 NORTH HIGHWAY		
City State Zip Code	44. NAICS code	45. Date form completed
JACKSON MN 56143		

46. **INSURER** name	51. **CLAIMS ADMIN COMPANY (CA)** name (check one) ☐ Insurer ☐ TPA	
RAS - RISK ADMINISTRATION SERVICES	RAS - RISK ADMINISTRATION SERVICES	
47. Insured legal name and FEIN	52. CA address	
JACKSON COUNTY CENTRAL SCHOOLS		
48. Policy # (including effective dates) or self-insured certificate #	City State Zip Code	
WC020-0039211-2018A		
49. Insurer FEIN / 50. Date insurer received notice	53. CA FEIN	54. CA claim #
411872029		

55. To be completed by the **CA**:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

Employer: Send copies to Insurer (or Workers' Compensation Division if no insurer), employee, and employee's union (if applicable)