THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKERS' COMPENSATION LAW

WCC Form 2
Rev. 9/2006

# STATE OF ALABAMA
## EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Ombudsman 1-800-528-5166

*Check here for* ***Record Only*** ☐

### CLAIM REFERENCE

| 1. Insured Report Number | 2. Filing Office Claim Number | 3. OSHA Log Case Number |
|---|---|---|
| | | |

### EMPLOYER

| | |
|---|---|
| 4. Employer Business Name<br>5. Physical Address 1<br>6. Physical Address 2<br>7. City 8. State 9. Zip | ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS<br>10. Mailing Address 1<br>11. Mailing Address 2 or Telephone Number<br>12. City 13. State 14. Zip |

| 15. Federal ID Number | 16. U.C. Account Number | 17. NAICS |
|---|---|---|
| | | |

### INSURER / FILING OFFICE

| | |
|---|---|
| 18. Insurer Name **AL SELF-INSURED WC FUND**<br>19. Insurer Federal ID Number **63-0773197**<br>20. Type Insurer ☐ Insurance Co. Ins Co #<br>☐ Self-Insurer SI #<br>☒ Group Fund GF # | 21. Filing Office Name **Employer's Claim Mgt., Inc.** 21a. Service Co. #<br>22. Mailing Address 1 **P.O. Box 5614**<br>23. Mailing Address 2 or Telephone Number **(334)277-9395**<br>24. City **Montgomery** 25. State **AL** 26. Zip **36103-5614**<br>27. Filing Office Federal ID Number **63-1034984** |

### EMPLOYEE / WAGES

| | |
|---|---|
| 28. First Name<br>29. Middle Name<br>30. Last Name<br>31 Last Name Suffix (ie. Jr., Sr., III) | 32. Employee ID Number<br>33. Type Employee ID Number<br>SSN ☐ Passport Number ☐ Green Card ☐<br>Employment Visa ☐ Assigned by Jurisdiction ☐ |

| | | |
|---|---|---|
| 34. Mailing Address 1<br>35. Mailing Address 2<br>36. City 37. State 38. Zip 39. Phone | 40. Gender<br>Male ☐<br>Female ☐ | 41. Date of Birth<br>42.Nbr of Dependents |

| | |
|---|---|
| 43. Marital Status<br>Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐ | 44. Date Hired |
| 45. Occupation Description | 46. Number of Days Worked Per Week |
| 47. Wages $<br>48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ | 49. Received Full Pay For Day of Injury? Yes ☐ No ☐<br>50. Did Salary Continue? Yes ☐ No ☐ |

### INJURY / TREATMENT

| 51. Date of Injury | 52. Time of Injury<br>a.m. ☐ p.m. ☐ unk ☐ | 53. Time Employee Began Work<br>a.m. ☐ p.m. ☐ | 54. Date Disability Began | 55. Date of Death |
|---|---|---|---|---|
| | | | | |

| | |
|---|---|
| PLACE OF ACCIDENT, INJURY, OR EXPOSURE<br>56. Site Address<br>57. City 58. State 59. Zip 60. County | 61. Injury Occurred on Employer's Premises?<br>Yes ☐ No ☐<br>62. Date Employer Notified |

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. ( Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

**PROVIDE DESCRIPTION CODES** to identify **Nature of Injury, Part of Body** that was affected, and **Cause of Injury.**
**(FOR COMPLETE LIST OF CODES, GO TO HTTP:// DIR.ALABAMA.GOV/WC**

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

| | |
|---|---|
| 67. Initial Treatment<br>No Medical Treatment ☐ First Aid By Employer ☐<br>Minor Clinic / Hospital ☐ Emergency Room ☐<br>Hospitalized > 24 Hours ☐ Major medical/Lost time ☐<br>Hospitalized Overnight ☐ | 68. Name of Treatment Facility<br>69. Address<br>70. City 71. State 72. Zip |

| | | |
|---|---|---|
| 73. Name of Physician or Other Health Care Professional | 74. Has Injured Returned to Work<br>Yes ☐ No ☐ | If so, 75. Date<br>76. Time a.m. ☐ p.m. ☐ |

### OTHER

| 77. Date Prepared | 78. Preparer's First Name 79. Last Name 80. Title | 81. Preparer's Telephone Number |
|---|---|---|
| | | |