# EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

(Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.)

1. WCB FILE NUMBER (if known): DN5

1a. OSHA 300 CASE NUMBER (if applicable): NA

**REASON FOR REPORT (check all that apply)**

2a. ☐ LOST TIME - ONE OR MORE DAYS DN74
2b. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO NA
3. ☐ LOST EARNINGS BUT NO LOST TIME NA
4. ☐ MEDICAL/HEALTH CARE DN74
5. ☐ FATALITY DATE OF DEATH: ____/____/____ MM DD YYYY DN57 Also see DN146
6a. ☐ OCCUPATIONAL DISEASE DN290
6b. DATE OF LAST EXPOSURE: ____/____/____ MM DD YYYY DN31
6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ MM DD YYYY NA
7a. ☐ CORRECT PRIOR REPORT DN2 Note: also see correction process & DN295, 296
7b. DATE OF CORRECTION: ____/____/____ MM DD YYYY DN3
7c. DATE CORRECTION SENT TO WCB: ____/____/____ MM DD YYYY DN3

| | | | | |
|---|---|---|---|---|
| 8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN): DN329 | 9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): DN16 | | 10. EMPLOYER NAME: DN18 | |
| 11. STREET/P.O BOX MAILING ADDRESS: DN168-169 | 12. CITY: DN165 | 13. STATE: DN170 | 14. ZIP: DN167 | 15. TELEPHONE NUMBER: DN159 ( ) |
| 16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED: DN25 | 17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS: DN19-23 EMPLOYER PHYSICAL COUNTRY CODE = DN164 | 18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO DN249<br>IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED: DN120; 119, 122, 121, 123, 33, 118 ACCIDENT SITE COUNTRY CODE = DN280 | | |

**(check one) ☐ INSURER ☐ THIRD PARTY ADMINISTRATOR (TPA) ☐ SELF-ADMINISTERED EMPLOYER**

| | | | | |
|---|---|---|---|---|
| 19. INSURANCE / TPA COMPANY NAME: DN7/188 | 20. POLICY NUMBER: DN28 | | 21. INSURER FILE NUMBER: DN15 | |
| 22. STREET/P.O. BOX MAILING ADDRESS: DN10-11 | 23. CITY: DN12 | 24. STATE: DN13 | 25. ZIP: DN14 | 26. TELEPHONE NUMBER: ( ) NA |

| | | | | | |
|---|---|---|---|---|---|
| 27. LAST NAME: DN43 & DN255 | 28. FIRST NAME: DN44 | 29. MI: DN45 | 30. TELEPHONE NUMBER: ( ) DN51 | 31. SOCIAL SECURITY NUMBER: DN42 | 32. GENDER: DN53 ☐ MALE ☐ FEMALE |
| 33. STREET/P.O. BOX MAILING ADDRESS: DN46-47 | 34. CITY: DN48 | | 35. STATE: DN49 | 36. ZIP: DN50 | 37. DATE OF BIRTH: DN52 ____/____/____ MM DD YYYY |
| 38. OCCUPATION/JOB TITLE: DN60 | 39. DATE OF HIRE: DN61 ____/____/____ MM DD YYYY | 40. WEEKLY WAGE AT TIME OF INJURY: $ DN62 | | 41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐YES ☐ NO IF YES, GIVE NAME AND ADDRESS: NA | |

| | | | |
|---|---|---|---|
| 42. DATE OF INJURY OR ILLNESS: ____/____/____ DN31 MM DD YYYY<br>DATE EMPLOYER NOTIFIED: ____/____/____ DN40 MM DD YYYY | 43. DATE OF INCAPACITY: ____/____/____ DN56 MM DD YYYY<br>DATE EMPLOYER NOTIFIED: ____/____/____ DN281 MM DD YYYY | 44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): NA<br>46. TIME OF INJURY (e.g. 1:10 p.m.): DN32 | 45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ DN41 MM DD YYYY<br>47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO DN 189<br>IF YES, GIVE DATE: ____/____/____ DN68 MM DD YYYY |
| 48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis): DN35 | 49. BODY PART(s) AFFECTED (e.g. lower right forearm): DN36 | | 50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate): DN37 |
| 51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): NA | | 52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.): DN38 | |

| | | | | |
|---|---|---|---|---|
| 53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO NA | 54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO: NA | 55. HEALTH CARE PROVICER NAME: NA | 56. MAILING ADDRESS: NA | 57. TELEPHONE NUMBER: ( ) NA |

| | | |
|---|---|---|
| 58. PREPARER NAME AND TITLE (TYPE OR PRINT): NA | 59. TELEPHONE NUMBER: ( ) NA | 60. DATE SENT TO WCB: DN100 ____/____/____ MM DD YYYY |

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DISTRIBUTION: COPY (1) MAINE WORKERS' COMPENSATION BOARD, 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER.

# EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE, WCB-1

**General Reporting Requirements**

The employer or claims administrator (CA) must file* a First Report (FROI) with the Board to report an employee injury that has caused the employee to lose a day's work.

A day, for the purposes of filing a FROI, is the number of hours or wages in an employee's regular workday. If an employee does not have a regular workday, then average hours or wages should be used. See Board Rule 3.1 for specific examples.

Lost Time: The FROI must be filed* within seven (7) days after the employer receives notice or knowledge of an employee injury that has caused the employee to lose a day's work.

When an employee loses a day or more from work that does not result in the filing of a Memorandum of Payment or a Notice of Controversy, the employer or CA shall file* an updated FROI within seven (7) days of the employee's return to work date. This step is unnecessary if the return to work date was previously reported on the original/initial FROI.

Death: If the employee dies as a result of a job-related injury or if the employee dies at the work site, regardless of the reason for death, the employer/CA must file* a FROI.

Medical Only: The employer/CA must complete a FROI within seven (7) days of notice or knowledge of an employee injury that requires the services of a health care provider, but there is no obligation to file it with the Board unless the injury later causes the employee to lose a day's work.

If the employer or CA disputes a medical bill on a claim for which a FROI was never filed, the employer or CA must file* the FROI.

Two Injuries on Same Day at Same Employer: In the event that an employee alleges two separate injuries on the same date while working for the same employer, only one FROI may be filed via EDI. The other FROI must be sent to the Board (in accordance with the guidelines established above) via e-mail, via fax (207-287-5895), or via standard mail at the following address:

Workers' Compensation Board
27 State House Station
Augusta, ME 04333-0027

Please call 207-287-7197 before sending the paper FROI so that it does not get rejected.

* accepted EDI transaction, with or without errors ("TE" or "TA" only)

**EDI Reporting Requirements**

Unless a waiver has been granted, effective July 1, 2005, all FROIs (see above exception for two injuries on same day at same employer) shall be filed* using the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Release 3 format. See Board Rule 3.4. Following is a general overview. More detailed information can be found at: http://www.state.me.us/wcb/departments/technology/electronic.htm.

Each transaction requires a Maintenance Type Code (MTC/DN0002). MTC/DN0002 is a code that identifies the type of FROI transaction:

| MTC | Definition |
|---|---|
| 00 | Original: The original/initial FROI, including the re-transmission of a FROI that was rejected due to a critical error, or a FROI that was previously cancelled. |
| 01 | Cancel: Cancel/delete FROI from the Board's system. The original/initial FROI was sent in error. The jurisdiction claim number/WCBN is mandatory for this transaction. |
| 02 | Change/Update: Change/update FROI. The jurisdiction claim number/WCBN is mandatory for this transaction. |
| CO | Correction: Correct transaction reported on the AKC as "TE" (see below). This transaction must contain the Maintenance Type Correction Code (MTCC) and Maintenance Type Correction Code Date (MTCC Date) fields. These fields communicate which report is being corrected. The jurisdiction claim number/WCBN is mandatory for this transaction. |
| 04 | Full Denial: A FROI 04 transaction indicates an original/new FROI and the filing of a Full Denial simultaneously. This MTC can only be used if the FROI has never been filed with the Board. |
| AQ | Acquired Claim: Report that a new CA has acquired the claim. The jurisdiction claim number/WCBN is mandatory for this transaction. |
| AU | Acquired/Unallocated Claim: The equivalent of a FROI 00 filed by new CA. |
| UR | Upon Request: Submitted in response to a specific request. If the Board receives a subsequent report of injury (MOP, Petition) for an employee for a date of injury that is not in the Board's system, a letter will be sent to the CA requesting that a FROI UR be sent. There is no other circumstance in which a FROI UR should be sent to the Board. The jurisdiction claim number/WCBN is mandatory for this transaction. |

* accepted EDI transaction, with or without errors ("TE" or "TA" only)

Each transaction requires a Claim Type Code (DN0074). DN0074 is a code representing the current classification of the claim:

| DN0074 | Definition |
|---|---|
| M | Medical Only. |
| I | Lost Time/Indemnity. |
| N | Notification Only. |
| B | Became Medical Only. |
| L | Became Lost Time/Indemnity. |

Each transaction is acknowledged with an Application Acknowledgement Code (DN0111) used to identify the accepted/rejected status of the transaction being acknowledged:

| DN0111 | Definition |
|---|---|
| HD | Batch Rejected: Batch rejected in its entirety. |
| TA | Transaction Accepted: The transaction was accepted without errors. |
| TE | Transaction Accepted with Error: An error was found on an expected data element. A CO (Correction) must be submitted to resolve the error(s). |
| TN | Transaction Rejected by Service Provider: The transaction fails mandatory requirements. |
| TR | Transaction Rejected: The transaction was not accepted. An error was found on a mandatory or mandatory conditional data element. A review of the error(s) must take place to determine if the transaction should be resubmitted with the same MTC – correcting the error. If an error of duplicate transaction, invalid event sequence, etc. then resubmission may not be required. |

It is the CA's responsibility to maintain the Acknowledgment (AKC) for every batch of EDI transactions sent to the Board. A FROI is not considered filed with the Board until it receives a "TA" or "TE" code on the AKC.

**Corrections**

Changes and corrections to FROIs must be filed* via EDI. Please note the important difference between a change (MTC "02") and a correction (MTC "CO"), as outlined above.

* accepted EDI transaction, with or without errors ("TE" or "TA" only)

**Distribution**
WCB-1 (1/02) shall be mailed to the employee and the employer within 24 hours after the FROI is sent to the Board.

**Closure (required for all lost time FROIs)**
Closure of the FROI is required if a FROI is or should have been filed with the Board under §303. Closure occurs when one of the following actions is taken:

1) Return to Work: Where lost time is less than or equal to 7 days, the return-to-work date must be reported to the Board within 7 days of the employee's return to work by sending a FROI 02 transaction. This step is unnecessary if the return-to-work date was previously reported on the original/initial FROI.

2) Indemnity Payment: Where the initial claim for indemnity benefits is paid, a Memorandum of Payment must be sent to the Board on or before the 14th day payment is due under §205(2) and must be received at the Board by the 17th day (three mail days are provided for receipt by the Board where sent via standard mail).

3) Controversy: Where the initial claim for indemnity benefits is in dispute, a Notice of Controversy must be filed[*] on or before the 14th day payment is due under §205(2).

**Form Filing Violations**
Failure to file any Board-prescribed forms within established time frames is a violation under §360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

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[*] accepted EDI transaction, with or without errors ("TE" or "TA" only)

**INSTRUCTIONS FOR COMPLETING**
**EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE, WCB-1**

For instructional purposes, this Forms Manual indicates the WCB-1 Box # and description as listed on the paper form, the IAIABC Data Element Number (DN) and the data requirements of each field to assist CAs with electronic filing and paper distribution of FROIs. Specific technical questions can be answered by reviewing the Element Requirement Tables that are available at: http://www.state.me.us/wcb/departments/technology/edirule.htm.

Certain fields are mandatory at the time of the EDI transaction. If any "mandatory" fields are missing, incomplete or incorrect, the EDI transaction will completely reject, resulting in a "TR" on the AKC. A "TR" on the AKC means that the EDI transaction was completely rejected. The fatal error(s) that caused the rejection must be corrected and a new EDI transaction must be sent as if it had never sent it in before. Other fields are given an expected rating which indicates that the data in those fields is expected by the Board. If any "expected" fields are missing, incomplete or incorrect, the NOC will be accepted (filed) with errors. The error(s) must be corrected by submitting a MTC "CO" using the jurisdiction claim number/WCBN provided in the acknowledgement report.

1. WCB File Number (if known): **(Assigned for FROI 00, FROI 04, and FROI AU; Mandatory for FROI 01, FROI 02, FROI CO, FROI AQ and FROI UR) (DN5 – JURISDICTION CLAIM NUMBER)**
   Enter the file number assigned by the State of Maine to identify this claim**.**

1a. OSHA 300 Case Number (if applicable): **(Not on the IAIABC format)**

2a. ☐ Lost Time - One or More Days
   Check this box if the employee has lost a day's work or more **(DN74 - CLAIM TYPE CODE = I or L)**. If this box is checked, then 2b must be completed.

2b. Was Employee Paid for ½ Day or More on Day of Injury? ☐Yes ☐ No
   **(Not on the IAIABC format)** Check either Yes or No.

3. ☐ Lost Earnings But No Lost Time
   Check this box if the employee's earnings have been reduced because of the effects of this injury, but the employee has not lost a day's work or more **(Not on the IAIABC format).**

4. ☐ Medical/Health Care
   Check this box if the employee's injury has required the services of a healthcare provider **(DN74 - CLAIM TYPE CODE=B or M)**.

5. ☐ Fatality Date of Death:
   Check this box if the employee has died as a result of a job-related injury or if the employee died at the work site (DN146 – DEATH RESULT OF INJURY CODE=Y or U). If this box is checked, the date (MM/DD/YYYY) of the employee's death is mandatory **(DN57 – EMPLOYEE DATE OF DEATH).**

6a. ☐ Occupational Disease

Check this box if the employee's occupational injury, illness or death is one of the following: loss of hearing, silicosis, asbestos-related disease, or exposure to radioactive properties. **(DN290 – TYPE OF LOSS CODE=02)**. **If this box is checked, then 6b and 6c must be completed.**

6b. Date of Last Exposure: **Do not complete this box if 6a is not checked.**

If box 6a is checked, enter the last date (MM/DD/YYYY) that the employee was exposed to the cause or condition from which the occupational disease arose **(DN31 – DATE OF INURY).**

6c. Date of Diagnosis as Occupationally Related: **Do not complete this box if 6a is not checked.)** If box 6a is checked, enter the date (MM/DD/YYYY) the injury, illness, or death was first diagnosed by a physician as being occupationally related. **(Not on the IAIABC format)**

7a. ☐ Correct Prior Report

Check this box if you are correcting a prior report **(DN2 – MAINTENANCE TYPE CODE= 02 or CO) If this box is checked, then 7b and 7c must be completed.**

7b. Date of Correction: **Do not complete this box if 7a is not checked.**

If box 7a is checked, enter the date (MM/DD/YYYY) that this form was corrected **(DN3 – MAINTENANCE TYPE CODE DATE)**

7c. Date correction Sent to WCB: **Do not complete this box if 7a is not checked.**

If box 7a is checked, enter the date (MM/DD/YYYY) that the corrected copy of this form was sent to the Board **(DN3 – MAINTENANCE TYPE CODE DATE)**

8. State Employer Unemployment Insurance Account Number (UIAN): **(Mandatory) (DN329 – EMPLOYER UI NUMBER)**

Enter the UIAN of the employer where the employee was employed at the time of the injury. This 10-digit number is assigned by the Maine Department of Labor to all employers who are liable for contributions for unemployment insurance. If the employer is not liable for contributions to unemployment insurance, the employer will not have a UIAN and must, therefore, call the Coverage Division of the Board (287-7092) to ask for an identification number.

9. Federal Employer Identification Number (FEIN): **(Expected) (DN16 - EMPLOYER FEIN)**

Enter the FEIN of the employer where the employee was employed at the time of the injury. This 9-digit number is assigned by the Federal Internal Revenue Service (IRS) to report all monies paid to the IRS. In some cases, this is the same as the employer's social security number.

10. Employer Name: **(Mandatory) (DN18 – EMPLOYER NAME)**

Enter the legal name of the employer.

11. Street/P.O. Box Mailing Address:

**DN168 – EMPLOYER MAILING PRIMARY ADDRESS (Expected)**
**DN169 – EMPLOYER MAILING SECONDARY ADDRESS (Expected Conditional)**

Enter the primary and secondary (if applicable) mailing addresses of the employer.

12. City: **(Expected) (DN165 – EMPLOYER MAILING CITY)**
    Enter the city of the employer's mailing address.

13. State: **(Expected) (DN170 – EMPLOYER MAILING STATE CODE)**
    Enter the state of the employer's mailing address.

14. Zip: **(Expected) (DN167 – EMPLOYER MAILING POSTAL CODE)**
    Enter the postal code of the employer's mailing address.

15. Telephone Number: **(If Available) (DN159 – EMPLOYER CONTACT BUSINESS PHONE NUMBER)**
    Enter the phone number of the employer, including area code.

16. Primary Business Performed by Employer Where Injury Occurred: **(If Available) (DN25 – INDUSTRY CODE)**
    Enter the code representing the nature of the employer's business which is contained in the industrial classification manual published by the Federal Office of Management and Budget.

17. Employer Location If Different from Mailing Address:
    **DN019 – EMPLOYER PHYSICAL PRIMARY ADDRESS (Expected Conditional)**
    **DN020 – EMPLOYER PHYSICAL SECONDARY ADDRESS (If Available)**
    **DN021 – EMPLOYER PHYSICAL CITY (Expected Conditional)**
    **DN022 – EMPLOYER PHYSICAL STATE CODE (Expected Conditional)**
    **DN023 – EMPLOYER PHYSICAL POSTAL CODE (Expected)**
    **DN164 – EMPLOYER PHYSICAL COUNTRY CODE (Expected Conditional)**
    Values: see http://www.iaiabc.org/
    Enter the employer's physical location if it differs from the employer's mailing address. If the employer has multiple locations, use the address for the place of business where the injured employee was working at the time of the injury.

18. Did Injury or Exposure Occur on Employer's Premises? **(Mandatory) (DN249 – ACCIDENT PREMISES CODE)** • Yes **(DN249=E)** • No **(DN249=L or X)**

    If No, Then Give Name and Physical Address of the Employer Where the Employee was Injured or Exposed: **(Expected Conditional)**
    **DN120 – ACCIDENT SITE ORGANIZATION NAME**
    **DN119 – ACCIDENT SITE LOCATION NARRATIVE** (location not post office identifiable)
    **DN122 – ACCIDENT SITE STREET**
    **DN121 – ACCIDENT SITE CITY**
    **DN123 – ACCIDENT SITE STATE CODE**
    **DN033 – ACCIDENT SITE POSTAL CODE**
    **DN118 – ACCIDENT SITE COUNTY/PARISH**
    **DN280 – ACCIDENT SITE COUNTRY CODE** Values: see http://www.iaiabc.org/

    If the employee was not injured on the employer's premises, then enter the name and physical address of the site where the employee was injured or exposed.

□ **Insurer** □ **Third-Party Administrator (TPA)** □ **Self-Administered Employer**

Check the box that describes the legal entity adjusting the claim.

19. Insurance/TPA Company Name: **(Expected) (DN7 – INSURER NAME/DN188 – CLAIM ADMINISTRATOR NAME)**

    Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim, and the legal name of the entity adjusting the claim.

20. Policy Number: **(Not Applicable) (DN28 – POLICY NUMBER)**

    Enter the policy number identifying the coverage policy in effect for the claim.

21. Insurer File Number: **(Mandatory) (DN15 – CLAIM ADMINISTRATOR CLAIM NUMBER)**

    Enter an identifier for a specific claim within the CA's processing system.

22. Street/P.O. Box Mailing Address:

    **DN10 – CLAIM ADMINISTRATOR PRIMARY ADDRESS (Expected)**
    **DN11 – CLAIM ADMINISTRATOR SECONDARY ADDRESS (If Available)**
    Enter the primary and secondary (if applicable) addresses of the CA.

23. City: **(Expected) (DN12 – CLAIM ADMINISTRATOR CITY)**

    Enter the city of the CA.

24. State: **(Expected) (DN13 - CLAIM ADMINISTRATOR STATE)**

    Enter the state of the CA.

25. Zip: **(Mandatory) (DN14 - CLAIM ADMINISTRATOR POSTAL CODE)**

    Enter the postal code of the CA.

26. Telephone number: **(Not on the IAIABC format)**

    Enter the telephone number, including area code, of the CA.

27. Last Name:

    **(DN43 – EMPLOYEE LAST NAME) (Mandatory)**
    **(DN255- EMPLOYEE LAST NAME SUFFIX) (If Available)**
    Enter the employee's legally recognized last name and last name suffix.

28. First Name: **(Mandatory) - (DN44 – EMPLOYEE FIRST NAME)**

    Enter the employee's first name.

29. MI: **(If Available) (DN45 – EMPLOYEE MIDDLE NAME/INITIAL)**

    Enter the employee's middle initial.

30. Home Phone #: **(If Available) (DN51 – EMPLOYEE PHONE NUMBER)**

    Enter the employee's home telephone number, including area code.

31. Social Security Number: **(Mandatory)**
    Enter the employee's ID #.
    Values: DN042 – EMPLOYEE SSN (DN270=S)
    DN152 – EMPLOYEE EMPLOYMENT VISA (DN270=E)
    DN153 – EMPLOYEE GREEN CARD (DN270=G)
    DN154 – EMPLOYEE ID ASSIGNED BY JURISDICTION (DN270=A)
    DN156 – EMPLOYEE PASSPORT NUMBER (DN270=P)

32. Gender: • Male • Female **(Expected) (DN53 – EMPLOYEE GENDER CODE=M or F)**
    Check either "M" for Male or "F" for Female to identify the employee's gender (check neither if DN53=U).

33. Street/P.O. Box Mailing Address:
    **DN46 – EMPLOYEE MAILING PRIMARY ADDRESS (Expected)**
    **DN47 – EMPLOYE MAILING SECONDARY ADDRESS (If Available)**
    Enter the primary and secondary mailing addresses of the employee.

34. City: **(Expected) – (DN48 – EMPLOYEE MAILING CITY)**
    Enter the city of the employee's mailing address.

35. State: **(Expected) – (DN49 – EMPLOYEE MAILING STATE CODE)**
    Enter the state of the employee's mailing address.

36. Zip: **(Expected) – (DN50 – EMPLOYEE MAILING POSTAL CODE)**
    Enter the postal code of the employee's mailing address.

37. Date of Birth: **(Expected) – (DN52 – EMPLOYEE DATE OF BIRTH)**
    Enter the date employee was born (MM/DD/YYYY).

38. Occupation/Job Title: **(Expected) (DN60 - OCCUPATION DESCRIPTION)**
    Enter the employee's primary occupation at the time of injury, e.g., legal secretary, file clerk, computer programmer, truck driver, etc. Describe what the employee does as clearly as possible. Avoid using jargon.

39. Date of Hire: **(Expected) – (DN61 – EMPLOYEE DATE OF HIRE)**
    Enter the date the employee began his/her employment with the employer under whose coverage the claim is being filed (MM/DD/YYYY). If there have been multiple periods of employment with the same employer, this would be the beginning date of the current employment period.

40. Weekly Wage at Time of Injury **(If Available) (DN62 – WAGE)**
    Enter the weekly wage the employee was receiving at the time of the injury.

41. Does Employee Work for Another Employer? • Yes • No **(Not on the IAIABC format)**

    Check either Yes or No.

    If Yes, Give Name and Address:
    Enter the name and address of any other employer(s) with whom the employee was employed at the time of the injury.

42. Date of Injury or Illness: **(Mandatory) (DN31 – DATE OF INJURY)**

    For traumatic injury, enter the date (MM/DD/YYYY) on which the accident occurred. For occupational disease or cumulative injury, enter the date of last injurious exposure to the cause or substance creating the condition.

    Date Employer Notified: **(Expected) (DN40 – DATE EMPLOYER HAD KNOWLEDGE OF THE INJURY)**

    Enter the earlier of the date that the accident was reported to the employer or the date that the employer had actual knowledge of the accident or injury (MM/DD/YYYY).

43. Date of Incapacity: **(Mandatory if DN74 – CLAIM TYPE CODE=I or L) (DN56 – INITIAL DATE DISABILITY BEGAN)**

    Enter the first day qualifying as a day of disability in the first period of disability (MM/DD/YYYY).

    Date Employer Notified: **(Mandatory if DN74 – CLAIM TYPE CODE=I or L) (DN281 – DATE EMPLOYER HAD KNOWLEDGE OF DATE OF DISABILITY)**

    Enter the date (MM/DD/YYYY) that the employer was notified or became aware of the employee's work-related disability/incapacity.

44. Time Employee Began Work: **(Not on the IAIABC format)**

    Enter the time the injured employee's workday began on the day of the injury.

45. Date Employer Notified Insurer/TPA: **(Expected) (DN41 – DATE CLAIM ADMINISTRATOR HAD KNOWLEDGE OF THE INJURY)**

    Enter the earlier of the date(s) the CA or the insurer first received notice of the accident or injury from any source (MM/DD/YYYY).

46. Time of Injury: **(Mandatory) (DN32 – TIME OF INJURY)**

    Enter the time of the accident/injury (military format).

47. Has Employee Returned to Work? • Yes • No If box 2a is checked, check either Yes or No. **(Do not check this box if 2a is not checked.)** Check either Yes or No.

    If Yes, Give Date: **(If Available) (DN68 – INITIAL RETURN TO WORK DATE)**
    Enter the date the employee returned to work at full or reduced wages, when applicable.

48. Specific Injury or Illness: **(Expected) (DN35 – NATURE OF INJURY CODE)**

    Enter the title corresponding to the Nature of Injury Code.
    Values: see [http://www.iaiabc.org/](http://www.iaiabc.org/)

49. Body Part(s) Affected: **(Expected) (DN36 – PART OF BODY INJURED CODE)**
    Enter the title corresponding to the Part of Body Injured Code.
    Values: see http://www.iaiabc.org/

50. All Equipment, Materials, or Chemicals Employee was Using When the Event Occurred: **(Expected) (DN37 – CAUSE OF INJURY CODE)**
    Enter the title corresponding to the Cause of the Injury Code.
    Values: see http://www.iaiabc.org/

51. Specify Activity the Employee was engaged in When the Event Occurred: **(Not on the IAIABC format)**
    Enter a brief description of what the employee was doing at the time of the injury. For example: welding, mowing grass, cooking, typing, moving furniture, etc.
    Was Activity Part of Normal Job Duties? • Yes • **(Not on the IAIABC format)**
    Check either Yes or No.

52. How Injury or Illness Occurred. Describe the Sequence of Events: **(Expected) (DN38 – ACCIDENT/INJURY DESCRIPTION NARRATIVE**)
    Enter a free form description of how the accident occurred and the resulting injuries.

53. Hospitalized Overnight as Inpatient? • Yes • No **(Not on the IAIABC format)**
    Check either Yes or No.

54. Was the Employee Treated in an Emergency Room? • Yes • No **(Not on the IAIABC format)**
    Check either Yes or No.

55. Health Care Provider Name: **(Not on the IAIABC format)**
    Enter the name of the health care provider, if any, who provided initial medical treatment.

56. Mailing Address: **(Not on the IAIABC format)**
    Enter the address of the health care provided reported in Box 55, if applicable.

57. Telephone Number: **(Not on the IAIABC format)**
    Enter the telephone number, including area code, of the health care provider reported in Box 55, if applicable.

58. Preparer Name and Title: **(Not on the IAIABC format)**
    Enter the preparer's name and title.

59. Telephone Number: **(Not on the IAIABC format)**
    Enter the telephone number, including area code, of the preparer reported in Box 58.

60. Date Sent to WCB: **(Mandatory) (DN100 – DATE TRANSMISSION SENT)**
    Enter the actual date (MM/DD/YYYY) the batch of data was sent via EDI to the Board.