INDIANA WORKER'S COMPENSATION
FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

Please return completed form electronically by an approved EDI process.

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

PLEASE TYPE or PRINT IN INK

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

Social Security number	Date of birth	Sex ☐ Male ☐ Female ☐ Unknown	Occupation / Job title	NCCI class code

Name (*last, first, middle*)	Marital status	Date hired	State of hire	Employee status
	☐ Unmarried			
Address (*number and street, city, state, ZIP code)*	☐ Married			
	☐ Separated			
	☐ Unknown			
Telephone number (include area code)	Number of dependents			

Hrs / Day	Days / Wk	Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued

Wage Per ☐ Hour ☐ Day ☐ Week ☐ Month

$ ☐ Year ☐ Other

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number

Address of employer (*number and street, city, state, ZIP code*)	Location number	Employer's location address (*if different*)
	Telephone number	
	Carrier / Administrator claim number	OSHA log number / Report purpose code

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

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate ☐ Self Insurance

Address of claims administrator (*number and street, city, state, ZIP code*)	☒ Insurance Carrier	Policy / Self-insured number
Telephone number	☐ Third Party Admin.	Policy period From To

Name of agent McGowan Insurance Group, Inc. | Code number

OCCURRENCE / TREATMENT INFORMATION

Date of Inj. / Exp.	Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined	Date employer notified	Type of injury / exposure	Type code

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

RTW date	Date of death	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 involved in accident
Specific activity engaged in during accident / exposure	Work process employee engaged in during accident / exposure

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

Cause of injury code

Name of physician / health care provider

Hospital or offsite treatment *(name and address)*

INITIAL TREATMENT
- ☐ No Medical Treatment
- ☐ Minor: By Employer
- ☐ Minor: Clinic / Hospital
- ☐ Emergency Care
- ☐ Hospitalized > 24 Hours
- ☐ Future Major Medical / Lost Time Anticipated

Name of witness	Telephone number	Date administrator notified

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).