EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

STATE EMPLOYEE INJURY COMPENSATION TRUST FUND (SEICTF)

Submit the online version of this form when possible by accessing our website at www.riskmgt.alabama.gov. This report is to be completed by a supervisor or other designated authority and faxed along with the Accident Report - Employee Statement form to 334-223-6170 or 888-827-6753 between 8 AM and 5 PM, Monday - Friday. If you need assistance contact SEICTF at 800-388-3406. All questions must be answered. Please type or print information on this form.

1. Name of Injured Employee Last First MI	**2. SSN** _____-____-_____	**3. Date of Birth** _____/_____/_____	**4. Sex** ____ M ____ F
5. Home Address No. and Street City or Town State Zip	**6. Phone** Home _____ Work _____ Cell _____ Work Hours: From: _____ To: _____		
7. Job Title / Job Code	**8. Status** _____ Full Time _____ Part Time _____ Contract	**9. Email address**	
10. Employing Agency -Agency Number	**11. Division, District, etc.**		
12. Agency Address - Number and Street	**City or Town**	**State**	**Zip**
13. Date of Injury _____/_____/_____	**14. Date Employer Notified** _____/_____/_____	**15. Time of Injury** ___:_____ _____AM _____ PM	

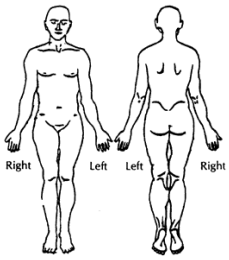
16. Is employee covered by State Employee Medical Insurance? _____ Yes _____ No

17. Has the injury or illness resulted in medical treatment? _____ Yes _____ No If yes, name and address of medical provider/facility.

18. Exact location where injury occurred include street address, building, room, parking lot, etc., if possible.	**19. Was injury caused by a motor vehicle accident?** **_____ Yes _____ No**

20. Was more than one person injured in this incident? _____ Yes _____ No

21. Describe the specific activity the employee was performing at the time the event or exposure occurred and what happened to cause the injury. Indicate the body part(s) affected by circling on the body chart below.



22. Could this accident have been prevented? _____ Yes _____ No If yes, what steps have been taken to prevent another accident?

23. Name all witnesses:
Name _____ **Daytime Phone** _____

Name _____ **Daytime Phone** _____

I am the supervisor of the employee making the claim for SEICTF benefits and have filled out this First Report of Injury based on the information that has been reported to me. I certify that the above information is true and correct to the best of my knowledge.

24. Signature of supervisor reporting incident	**Print Name**	**Daytime Phone**	**Date**