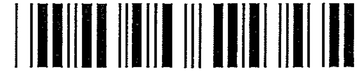
MN Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

First Report of Injury

See Instructions on Reverse Side.

PRINT IN INK or TYPE
ENTER DATES IN MM/DD/YYYY FORMAT



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. First date 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)

38. Mailing address | 39. Employer FEIN | 40. Unemployment ID #

City State Zip Code | 41. Employer's contact name and phone #

42. Physical address (if different) | 43. Witness (name and phone) – if more than 1 attach a separate sheet

City State Zip Code | 44. NAICS code | 45. Date form completed

46. INSURER name
League of Minnesota Cities Insurance Trust

51. CLAIMS ADMIN COMPANY (CA) name (check one) ☐ Insurer ☒ TPA
Berkley Risk Administrators Company, LLC

47. Insured legal name and FEIN

52. CA Address
145 University Avenue West

48. Policy # (including effective dates) or self-insured certificate #

City: St. Paul | State: MN | Zip Code: 55103-2044

49. Insurer FEIN
41-6007047

50. Date insurer received notice

53. CA FEIN
0698639002

54. CA Claim #

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?

LM 2510 (1/17)

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