ALL COPIES OF THIS FIRST REPORT MUST BE TYPED OR PRINTED

Department of Labor
Office of Workers' Compensation (OWC)
4425 N. Market Street
Wilmington, DE 19802
Telephone 302-761-8200

STATE OF DELAWARE
FIRST REPORT
OF OCCUPATIONAL INJURY OR DISEASE

OWC Case File No. _____

ALL INFORMATION IS REQUIRED, unless not applicable where "if applicable" is noted.

1. EMPLOYEE: FIRST / MIDDLE / LAST			**2. EMPLOYEE SOCIAL SECURITY NO.**	
3. ADDRESS – INCLUDE COUNTY AND ZIP CODE			**4.** MALE ☐ FEMALE ☐	**5. EMPLOYEE PHONE NUMBER (INCLUDING AREA CODE)**
6. DATE OF BIRTH / /	**7. AGE**	**8. WAGE**	**9. WEEKLY HOURS WORKED**	
10. OCCUPATION (REGULAR)	**11. DEPARTMENT OR DIVISION REGULARLY EMPLOYED**		**12. HOW LONG EMPLOYED**	
13. EMPLOYER:			**14. PERSON MAKING OUT THIS REPORT**	
15. ADDRESS – INCLUDE COUNTY AND ZIP CODE			**16. EMPLOYER PHONE # (INCLUDE AREA CODE)**	
17. MAILING ADDRESS – IF DIFFERENT THAN ABOVE			**18. NATURE OF BUSINESS – TYPE OF MFG., TRADE, CONSTURCTION, SERVICE, ETC.**	
19. WORKERS' COMPENSATION INSURANCE CARRIER			**20. WORKERS' COMP. INS. CARRIER PHONE #, (INCLUDING AREA CODE**	
21. WORKERS' COMP. INSURANCE CARRIER ADDRESS			**22. POLICY NUMBER / CARRIER CASE NUMBER:** /	
23. THIRD PARTY ADMINISTRATOR (TPA), IF APPLICABLE	**24. TPA ADDRESS – INCLUDE CITY STATE AND ZIPCODE**			
DATES: **25. DATE OF REPORT** / /	**26. DATE OF INJURY** / /	**27. NORMAL STARTING TIME** ☐ AM ☐ PM	**28. IF EMPLOYEE BACK TO WORK GIVE DATE** / /	**29. AT SAME WAGE?** YES ☐ NO ☐
30. IF FATAL INJURY, GIVE DATE OF DEATH / /	**31. DATE EMPLOYER KNEW OF INJURY** / /	**32. DATE DISABILITY BEGAN** / /	**33. LAST FULL DAY PAID-DATE** / /	

INJURY OR DISEASE:

34. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.

35. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.

OCCURRENCE:

36. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE USED WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.

37. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, E.G. LIFTING A PATIENT.

38. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED.

39. NAME OF PHYSICIAN (IF APPLICABLE)	**40. PHYSICIAN'S ADDRESS**
41. HOSPITAL (IF APPLICABLE)	**42. HOSPITAL ADDRESS**

DISTRIBUTION OF THIS REPORT (1 original and 3 copies)

1. **ORIGINAL MUST BE SENT IMMEDIATELY TO THE WORKERS' COMPENSATION INSURANCE CARRIER.**
2. **COPY TO THE OFFICE OF WORKERS' COMPENSATION (use the address at the top left of this form)**
3. **EMPLOYER'S COPY – RETAIN AS RECORD**
4. **EMPLOYEE'S COPY**