# 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. All questions on this form must be answered. A supervisor or other designated authority must complete this report and fax along with the Accident Report - Employee Statement form to 334-223-6170 or 888-827-6753 or submit via email to SEICTF@finance.alabama.gov. If you need assistance contact SEICTF at 800-388-3406, between 8 AM and 5 PM, Monday - Friday.**

**1. Name of Injured Employee**
Last First MI

**2. SSN**
_____-_____-_____

**3. Date of Birth**
_____/_____/_____

**4. Sex**
☐ M ☐ F

**5. Employee Mailing Address**
No. and Street

City or Town

State Zip

**6.Employee Phone**
Home

Cell

Work

Employee Work Hours:

From: _____ To: _____

Normal Scheduled Days Off:

☐MO ☐TU ☐WE ☐TH
☐FR ☐SA ☐SU

**7. Job Title / Job Code** **Employee Number**

**8. Employee Email address**

**9. Employment Status**
☐ Full Time ☐ Part Time ☐Contract ☐ Seasonal ☐Retiree ☐ Temporary

**10. Employing Agency - Agency Number**

**11. Division, District, Location, 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. On Agency Premises?**
☐ Yes ☐ No

**17. Is employee covered by State Employee Medical Insurance?** ☐ Yes ☐ No

**18. Could this accident have been prevented?** ☐ Yes ☐ No

**If yes, what steps have been taken to prevent another accident?**

**19. Has the injury or illness resulted in medical treatment?** ☐ Yes ☐ No

**If yes, name and address of medical provider/facility.**

**20. Exact location where injury occurred include street address, building, room, parking lot, etc., if possible.**

**21. Was injury caused by a motor vehicle accident?** ☐ Yes ☐ No **If yes, provide copy of police report to SEICTF.**

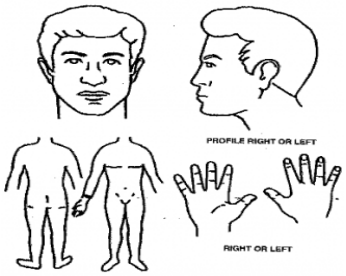
**22. Was more than one person injured in this incident?** ☐ Yes ☐ No

**If yes, provide name(s):**

**23. Describe exactly what the injured employee was doing and how the accident occurred.**

**24. Describe the injury (ies) received. Indicate if cut, bruise, sprain, strain, twist, pull, etc. (Give details below):**

_____
_____
_____
_____
_____
_____




**Indicate the body part(s) affected below and by circling on the body chart at left.**

| | |
|---|---|
| ☐ Head | ☐ Eye(s) |
| ☐ Left Arm | ☐ Right Arm |
| ☐ Left Hand | ☐ Right Hand |
| ☐ Left Leg | ☐ Right Leg |
| ☐ Back | ☐ Neck |
| ☐ Left Foot | ☐ Right Foot |
| ☐ Left Knee | ☐ Right Knee |
| ☐ Left Ankle | ☐ Right Ankle |

☐ Other _____

**25. Name all witnesses (Use additional paper as necessary):**
**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.**

| 26. Signature of supervisor reporting incident | Print Name and Email | Daytime Phone | Date |
|---|---|---|---|
| | | | |