



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 <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> MO <input type="checkbox"/> TU <input type="checkbox"/> WE <input type="checkbox"/> TH <input type="checkbox"/> FR <input type="checkbox"/> SA <input type="checkbox"/> SU
7. Job Title / Job Code Employee Number		8. Employee Email address		
9. Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Contract <input type="checkbox"/> Seasonal <input type="checkbox"/> Retiree <input type="checkbox"/> 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 ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM	16. On Agency Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Is employee covered by State Employee Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
18. Could this accident have been prevented? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what steps have been taken to prevent another accident?		
19. Has the injury or illness resulted in medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide copy of police report to SEICTF.				
22. Was more than one person injured in this incident? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Head <input type="checkbox"/> Eye(s) <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Hand <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Right Leg <input type="checkbox"/> Back <input type="checkbox"/> Neck <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Ankle <input type="checkbox"/> Right Ankle <input type="checkbox"/> 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