TRIBAL FIRST CLAIMS ADMINISTRATION

P.O. Box 609015
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EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

☐ Fatality

EMPLOYER

1. FIRM NAME
1A. POLICY NUMBER
2 MAILING ADDRESS (Number and Street, City, Zip)
2A. PHONE NUMBER
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)
3A. LOCATION CODE
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
6. TYPE OF EMPLOYER ☐ PRIVATE ☐ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY ____

EMPLOYEE

7. EMPLOYEE NAME
8. SOCIAL SECURITY NUMBER
9. DATE OF BIRTH (mm dd yy)
10. HOME ADDRESS (Number and Street, City, ZIP)
10A. PHONE NUMBER
11 SEX ☐ MALE ☐ FEMALE
12. OCCUPATION (Regular job title - NO initials, abbreviations or numbers)
13. DATE OF HIRE (mm dd yy)
14. EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total weekly hours
14A. EMPLOYMENT STATUS (check applicable status at time of injury) ____ regular full time ____ part-time ____ temporary ____ seasonal
14B. DEPARTMENT CODE
15 GROSS WAGES SALARY $____ per ____
16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging overtime, bonuses, etc.)? ☐ YES, $ ____ per ____ ☐ NO

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm dd yy)
18. TIME INJURY/ILLNESS OCCURRED ____ A.M. ____ P.M.
19. TIME EMPLOYEE BEGAN WORK ____ A.M. ____ P.M.
20. IF EMPLOYEE DIED, DATE OF DEATH (mm dd yy)
21 UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
22. DATE LAST WORKED (mm dd yy)
23. DATE RETURNED TO WORK (mm dd yy)
24. IF STILL OFF WORK, CHECK THIS BOX ☐
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
26. SALARY BEING CONTINUED? ☐ YES ☐ NO
27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm dd yy)
28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy)
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.
30 LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
30A. COUNTY
30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
31 DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g. shipping department, machine shop.
32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO
33 EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.
34 SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck
35 HOW INJURY/ILLNESS OCCURRED, DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
36A. PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
37A. PHONE NUMBER

DO NOT USE THIS COLUMN

Case No
Ownership
Industry
Occupation
Sex
Age
Daily hours
Days per week
Weekly hours
Weekly wage
County
Nature of injury
Part of body
Source
Event
Sec. Source
Extent of injury

Completed by (type or print)	Signature	Title	Date

TF-107 (12/99)

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY