EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)

2a. ☐ LOST TIME - ONE OR MORE DAYS 2b. WAS EMPLOYEE PAID FOR IJ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO

3. ☐ LOST EARNINGS BUT NO LOST TIME 4. ☐ MEDICAL/HEALTH CARE 5. ☐ FATALITY DATE OF DEATH: ____/____/____ MM DD YYYY

6a. ☐ OCCUPATIONAL DISEASE 6b. DATE OF LAST EXPOSURE: ____/____/____ MM DD YYYY 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ MM DD YYYY

7a. ☐ CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: ____/____/____ MM DD YYYY 7c. DATE CORRECTION SENT TO WCB: ____/____/____ MM DD YYYY

EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):	10. EMPLOYER NAME:
0068064007	016000089	Town of Brunswick

11. STREET/P.O BOX MAILING ADDRESS:	12. CITY:	13. STATE:	14. ZIP:	15. TELEPHONE NUMBER:
85 Union Street	Brunswick	ME	04011	(207) 725-6653

16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:	18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:

(check one) ☐ INSURER ☐ THIRD PARTY ADMINISTRATOR (TPA) ☐ SELF-ADMINISTERED EMPLOYER

19. INSURANCE / TPA COMPANY NAME:	20. POLICY NUMBER:	21. INSURER FILE NUMBER:

22. STREET/P.O. BOX MAILING ADDRESS:	23. CITY:	24. STATE:	25. ZIP:	26. TELEPHONE NUMBER:
				( )

EMPLOYEE

27. LAST NAME:	28. FIRST NAME:	29. MI:	30. TELEPHONE NUMBER:	31. SOCIAL SECURITY NUMBER:	32. GENDER:
			( )		☐ MALE ☐ FEMALE

33. STREET/P.O. BOX MAILING ADDRESS:	34. CITY:	35. STATE:	36. ZIP:	37. DATE OF BIRTH:
				____/____/____ MM DD YYYY

38. OCCUPATION/JOB TITLE:	39. DATE OF HIRE:	40. WEEKLY WAGE AT TIME OF INJURY:	41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER?
	____/____/____ MM DD YYYY	$	☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS:

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS:	43. DATE OF INCAPACITY:	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.):	45. DATE EMPLOYER NOTIFIED INSURER/TPA:
____/____/____ MM DD YYYY	____/____/____ MM DD YYYY		____/____/____ MM DD YYYY
DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	46. TIME OF INJURY (e.g. 1:10 p.m.):	47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO IF YES, GIVE DATE: ____/____/____ MM DD YYYY

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	49. BODY PART(s) AFFECTED (e.g. lower right forearm):	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): WAS ACTIVITY PART OF NORMAL JOB DUTIES? ☐ YES ☐ NO	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):

53. HOSPITALIZED OVERNIGHT AS INPATIENT?	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM?	55. HEALTH CARE PROVIDER NAME:	56. MAILING ADDRESS:	57. TELEPHONE NUMBER:
☐ YES ☐ NO	☐ YES ☐ NO:			( )

PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OR PRINT):	59. TELEPHONE NUMBER:	60. DATE SENT TO WCB:
	( )	____/____/____ MM DD YYYY

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY Maine Relay 711.