THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKERS'S COMPENSATION LAW

WCC Form 2
Rev. 9/2006

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE
Ombudsman 1-800-528-5166

CLAIM REFERENCE

1. Insured Report Number
2. Filing Office Claim Number
3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name
5. Physical Address 1
6. Physical Address 2
7. City 8. State 9. Zip

ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS
10. Mailing Address 1
11. Mailing Address 2 or Telephone Number
12. City 13. State 14. Zip

15. Federal ID Number
16. U.C. Account Number
17. NAICS

INSURER / FILING OFFICE

18. Insurer Name
19. Insurer Federal ID Number
20. Type Insurer ☐ Insurance Co. Ins Co # ☐ Self-Insurer SI # ☐ Group Fund GF #

21. Filing Office Name 21a. Service
22. Mailing Address 1
23. Mailing Address 2 or Telephone Number
24. City 25. State 26. Zip
27. Filing Office Federal ID Number

EMPLOYEE / WAGES

28. First Name
29. Middle Name
30. Last Name
31 Last Name Suffix (ie. Jr., Sr., III)

32. Employee ID Number
33. Type Employee ID Number
SSN ☐ Passport Number ☐ Green Card ☐ Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1
35. Mailing Address 2
36. City 37. State 38. Zip 39. Phone

40. Gender Male ☐ Female ☐
41. Date of Birth
42.Nbr of Dependents

43. Marital Status
Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐

44. Date Hired

45. Occupation Description
46. Number of Days Worked Per Week

47. Wages $
48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐

49. Received Full Pay For Day of Injury? Yes ☐ No ☐
50. Did Salary Continue? Yes ☐ No ☐

INJURY / TREATMENT

51. Date of Injury
52. Time of Injury a.m. ☐ p.m. ☐ unk ☐
53. Time Employee Began Work a.m. ☐ p.m. ☐
54. Date Disability Began
55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE
56. Site Address
57. City 58. State 59. Zip 60. County

61. Injury Occurred on Employer's Premises? Yes ☐ No ☐
62. Date Employer Notified

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// DIR.ALABAMA.GOV/WC

64. Nature of Injury Code
65. Part of Body Code
66. Cause of Injury Code

67. Initial Treatment
No Medical Treatment ☐ First Aid By Employer ☐
Minor Clinic / Hospital ☐ Emergency Room ☐
Hospitalized > 24 Hours ☐ Major medical/Lost time ☐
Hospitalized Overnight ☐

68. Name of Treatment Facility
69. Address
70. City 71. State 72. Zip

73. Name of Physician or Other Health Care Professional

74. Has Injured Returned to Work Yes ☐ No ☐
If so, 75. Date
76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared
78. Preparer's First Name
79. Last Name
80. Title
81. Preparer's Telephone Number

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03/01/2006