MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

REPORT OF INJURY

P.O. Box 58
Jefferson City, MO 65102-0058

(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*	CARRIER ADMINISTRATOR CLAIM NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER
	INSURED REPORT NUMBER	
	EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)*	LOCATION #
SIC CODE / EMPLOYER FEIN		PHONE #

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*	POLICY PERIOD	CLAIMS ADMINISTRATOR *(NAME, ADDRESS & PHONE NO.)*
Missouri Nursing Home Insurance Trust 3215 S. Providence Rd., Suite 4 Columbia, MO 65203	1/1/ to 1/1/ CHECK IF APPROPRIATE ☒ SELF INSURANCE	Maxim Insurance Solutions, LC 3215 S. Providence Rd., Suite 4 Columbia, MO 65203

CARRIER FEIN	INSURANCE POLICY NUMBER	ADMINISTRATOR FEIN
43-1490843	SIG0021	06-1660064

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)*	DATE OF BIRTH	SOCIAL SECURITY #	DATE HIRED	STATE OF HIRE

ADDRESS *(INCLUDE ZIP)*

SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN

MARITAL STATUS: ☐ UNMARRIED SINGLE DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN

OCCUPATION JOB TITLE

EMPLOYMENT STATUS

PHONE #

OF DEPENDENTS

NCCI CLASS CODE

WAGE

RATE PER ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER

OF DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME PHONE NUMBER	TYPE OF INJURY ILLNESS	PART OF BODY AFFECTED
DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.

CAUSE OF INJURY CODE

DATE RETURN TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREAT-MENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*

HOSPITAL *(NAME & ADDRESS)*

INITIAL TREATMENT
- ☐ 0 – NO MEDICAL TREATMENT
- ☐ 1 – MINOR: BY EMPLOYER
- ☐ 2 – MINOR CLINIC HOSPITAL
- ☐ 3 – EMERGENCY CASE
- ☐ 4 – HOSPITALIZED > 24 HOURS
- ☐ 5 – FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER