

WC Form 2  
Rev. 1-93

STATE OF ALABAMA  
EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

OMBUDSMAN 1-800-528-5166

Send to: Your workers' compensation insurance carrier, in duplicate

PRINT OR TYPE

EMPLOYER	1. EMPLOYER'S NAME AND MAILING ADDRESS (As shown on Insurance Policy or S. I. Certificate) (No. & Street, City, County, State, ZIP)		LOCATION, IF DIFFERENT FROM MAILING ADDRESS		Do Not Write In The Space Below	
	TELEPHONE NUMBER					
	2. EMPLOYER IDENTIFICATION (U. C. ACCOUNT) NUMBER		3. CARRIER OR SELF-INSURANCE REGISTRATION NUMBER		Employer U. C. ←	
	4. NATURE OF BUSINESS (Manufacturing, Trade, Transportation, etc.)		SPECIFIC PRODUCTS		Carrier Number ←	
	5. WORKERS' COMPENSATION PROVIDED BY: INSURANCE CARRIER ( ) SELF-INSURANCE ( ) GROUP FUND ( ) IF INSURANCE CARRIER, GIVE NAME AND ADDRESS:				SIC	
EMPLOYEE	6. EMPLOYEE'S NAME (Last) (First) (Middle)		7. SEX MALE ( ) FEMALE ( )	8. AGE	9. SOCIAL SECURITY NO.	Soc. Sec. No. ←
	10. EMPLOYEE'S HOME ADDRESS (No. & Street or RFD, City, County, State, ZIP)		11. MARITAL STATUS: SINGLE ( ) MARRIED ( ) DIVORCED ( ) SEPARATED ( ) WIDOWED ( )		Sex	
	12. HOME TELEPHONE	13. REGULAR OCCUPATION		14. WORKING IN WHAT DEPARTMENT WHEN HURT		Marital Status
	15. PLACE OF ACCIDENT OR EXPOSURE (Address or location, include County)		16. ON EMPLOYER'S PREMISES? YES ( ) NO ( )		Dependents	
17. Date of Occurrence		18. TIME OF DAY a.m. ( ) p.m. ( )	19. Date Disability Began		20. Date Employer Notified	Age
21. DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED. (E.g., amputation of right index finger at second joint, fracture of 2 ribs, lead poisoning, dermatitis of left hand, etc.)		22. IF FATAL, GIVE DATE OF DEATH		23. WHAT THING DIRECTLY PRODUCED THIS INJURY OR ILLNESS? (Name object struck against or struck by; vapor, poison, chemical or radiation; if strain or hernia, the thing being lifted, pulled, pushed, etc.; if injury resulted solely from bodily motion, the stretching, twisting, etc. which resulted in injury.)		Occupation
24. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Begin by telling what the employee was doing just before the accident or exposure. Be specific. If employee was using tools or equipment, or handling material, name them and tell what employee was doing with them.)		25. NAME AND ADDRESS OF TREATING PRACTITIONER		NAME AND ADDRESS OF HOSPITAL HOSPITALIZED ( ) OUT-PATIENT ( ) EMERGENCY TREATMENT ( )		Event County
26. Has Injured Returned to Work? Yes ( ) No ( )		27. If so, Date	28. At What Wage?	29. At What Occupation?		On Premises
30. LENGTH OF TIME IN YOUR EMPLOY? Years _____ Months _____		31. LENGTH OF TIME IN PRESENT JOB Years _____ Months _____		32. NUMBER OF DEPENDENTS		Event Date
33. Average Weekly Wage		34. Weekly Value of Remuneration Other Than Wages-(Food, Lodging, etc.) \$		35. DID EMPLOYEE RECEIVE FULL PAY FOR DAY OF INJURY? YES ( ) NO ( )		Paid Day Injury
36. Date of This Report		37. Signed by		38. Signature		Employer Knew
						Injury Source
						Accident Type
						Nature of Injury
						Part of Body
						Date of Death
						Stopped Work
						Time Employed
						Time in Job
						Weekly Wage
						Report Date
						Report Received
						Back to Work
						Case Class