

**EMPLOYER'S REPORT  
OF OCCUPATIONAL  
INJURY OR ILLNESS**

**Tribal First / NovaPro Risk Solutions**

4313 6th Avenue SE, Suite A

Lacey, WA 98503

Fax: (360) 413-9291

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1. FIRM NAME	1A. POLICY NUMBER	<b>DO NOT USE THIS COLUMN</b>
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. EMPLOYEE NAME	6. SOCIAL SECURITY NUMBER	7. DATE OF BIRTH (mm dd yy)	Age
8. HOME ADDRESS (Number and Street, City, ZIP)		8A. PHONE NUMBER	Daily hours
9. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	10. OCCUPATION (Regular job title - NO initials, abbreviations or numbers)	11. DATE OF HIRE (mm dd yy)	Days per week
12. EMPLOYEE USUALLY WORKS hours per day _____ days per week _____ total weekly hours _____	12A. EMPLOYMENT STATUS (check applicable status at time of injury) regular full time _____ part-time _____ temporary _____ seasonal _____	12B. DEPARTMENT CODE	Weekly hours
13. GROSS WAGES SALARY \$ _____ per _____	14. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging overtime, bonuses, etc.)? <input type="checkbox"/> YES, \$ _____ per _____ <input type="checkbox"/> NO		
15. Do you have more than one paying job? <input type="checkbox"/> YES <input type="checkbox"/> NO			
15A. Married? <input type="checkbox"/> YES <input type="checkbox"/> NO		15B. Dependents? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**MEDICAL RELEASE AUTHORIZATION:** I hereby authorize my physician, hospital, agency, or organization to disclose to my employer or their representatives, any medical records or other information regarding treatment which has previously been furnished to me.

**NOTICE:** Indian reservations are sovereign nations and are not subject to the state or federal workers' compensation laws. By completion of this form you are submitting to the sole jurisdiction of the tribe. NOTICE: Making or causing to be made any knowingly false or fraudulent material statement written or oral, or purposefully withholding material information in order to receive compensation is unlawful and will result in a denial of benefits, penalties, and/or prosecution.

16. Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

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)	Weekly wage
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. DATE LAST WORKED (mm dd yy)	23. DATE RETURNED TO WORK (mm dd yy)	County
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> YES <input type="checkbox"/> NO	26. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> 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)	Nature of injury
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.				Part of body
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)		30A. COUNTY	30B. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	Source
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g. shipping department, machine shop.			32. OTHER WORKERS INJURED/ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.				Sec. Source
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck				Extent of injury
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

Employer comments/concerns \_\_\_\_\_

Completed by (type or print) \_\_\_\_\_ Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_