Reference No:

Central Office use only:
Incident No:

Claim No:

DAS
First Report of Injury WC 207

The Supervisor must complete this form with the injured worker and then forward it along with the balance of the claim package to the Workers' Compensation Unit within 24 hours.

1. AgencyLocationCode	2. Division/Region			
3.SSN	4.Employee Number	5.Name of Injured Worker *(First) (Last) (MI)*		
6.Home Address (City or Town) (State) (Zip)		7.Home Telephone	8.Date of Birth	9.Sex
10.Job Classification		11. Date of Hire	12.Date of Incident	13.Time of Incident
14.Time Employer Notified	15.Date Employer Notified	16. Was Injury Fatal? YES ☐ NO ☐	17. Date of Fatality	

18. How Did the Injury Occur?

19. Type of Injury	20. Body Part(s) Affected	21. Category of Illness or Injury
22. Did Injury Occur on Employer Premises? ☐ YES ☐ NO	23. Location Injury Occured	
24. Injured Worker Seeking Medical Treatment ☐ YES ☐ NO If yes complete question 25	25. Medical Care Provided By: (Physician Name and Address)	

26. Were There Any Witnesses to the Injury?
(If yes, give name, address and phone.)

27. To Whom Was Injury Reported? (Name) (Title)

28. SUPERVISOR CONTACT INFO
Please print

Name:

Work Phone:

Best Time to Contact:

I HAVE REVIEWED THE ABOVE FORM FOR COMPLETENESS

29. Signature of Supervisor (or other Designated Authority)

SUPERVISORS REPORT ALL INJURIES - CALL 1-800-828-2717

white agency copy *yellow* agency copy *pink* employee copy