STATE OF DELAWARE FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

Department of Labor
Office of Workers' Compensation (OWC)
4425 N. Market Street
Wilmington, DE 19802
Telephone 302-761-8200

OWC Case File No. _____

ALL INFORMATION IS REQUIRED, unless not applicable where "if applicable" is noted.

1.EMPLOYEE: FIRST MIDDLE LAST			2. EMPLOYEE SOCIAL SECURITY NO.
3. **ADDRESS – INCLUDE COUNTY AND ZIP CODE**		4. **MALE** ☐ **FEMALE** ☐ **UNSPECIFIED** ☐	5. **EMPLOYEE PHONE NUMBER (INCLUDING AREA CODE)**
6. DATE OF BIRTH / /	7.AGE	8. WAGE	9. WEEKLY HOURS WORKED
10. OCCUPATION (REGULAR)	11. DEPARTMENT OR DIVISION REGULARLY EMPLOYED		12. HOW LONG EMPLOYED
13. **EMPLOYER:**		14. **PERSON MAKING OUT THIS REPORT**	
15. ADDRESS - INCLUDE COUNTY AND ZIP CODE		16. EMPLOYER PHONE# (INCLUDE AREA CODE)	
17. MAILING ADDRESS-IF DIFFERENT THAN ABOVE		18. NATURE OF BUSINESS -TYPE OF MFG., TRADE, CONSTRUCTION, SERVICE, ETC.	
19. **WORKERS' COMPENSATION INSURANCE CARRIER**		20. **WORKERS' COMP INS. CARRIER PHONE # (INCLUDING AREA CODE)**	
21. WORKERS' COMP. INSURANCE CARRIER ADDRESS		22. POLICY NUMBER/ CARRIER CASE NUMBER:	
23. THIRD PARTY ADMINISTRATOR (TPA), IF APPLICABLE	24. TPA ADDRESS- INCLUDE CITY STATE AND ZIPCODE		
DATES: 25. DATE OF REPORT / /	26. DATE OF INJURY / /	27. NORMAL STARTING TIME AM ☐ PM ☐	28. IF EMPLOYEE BACK TO WORK GIVE DATE / /	29. AT SAME WAGE? YES ☐ NO ☐
30. IF FATAL INJURY, GIVE DATE OF DEATH / /	31. DATE EMPLOYER KNEW OF INJURY / /	32. DATE DISABILITY BEGAN / /	33. LAST FULL DAY PAID-DATE / /	
INJURY OR DISEASE: 34. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.				
35. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.				
OCCURRENCE: 36. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE USED WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.				
37. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, E.G. LIFTING A PATIENT.				
38. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED.				
39. NAME OF PHYSICIAN (IF APPLICABLE)	40. PHYSICIAN'S ADDRESS			
41. HOSPITAL (IF APPLICABLE)	42. HOSPITAL ADDRESS			

DISTRIBUTION OF THIS REPORT (1 original and 3 copies)

1. ORIGINAL MUST BE SENT IMMEDIATELY TO THE WORKERS' COMPENSATION INSURANCE CARRIER.
2. COPY TO THE OFFICE OF WORKERS' COMPENSATION (use the address at the top left of this form)
3. EMPLOYER'S COPY - RETAIN AS RECORD
4. EMPLOYEE'S COPY

WORKERS' COMPENSATION

IMPORTANT THINGS TO DO IN CASE OF INJURY

THE EMPLOYER SHOULD:

1. Provide all necessary medical, surgical and hospital treatment from the date of accident.
2. Every employer shall keep a record of all injuries received by employees and make a report within 10 days thereof in writing to the Office of Workers' Compensation
3. Ascertain the average weekly wages of the employee and provide compensation in accordance with the provisions of the law, for disability *beyond the third day* after the accident. All agreements as to compensation must be submitted to the Office of Workers' Compensation for approval.

THE EMPLOYEE SHOULD:

1. Immediately notify the employer in writing of accidental injury or occupational disease and request medical services. Failure to give notice or to accept medical services may deprive the employee of the right to compensation.
2. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the law, file application with the Industrial Accident Board for a hearing on the matters at issue within two years of the date of accidental injury or one year of knowledge of the diagnosis of an occupational disease or an ionizing radiation injury. All forms can be obtained from the Office of Workers' Compensation.

SUBMIT