

# MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)  Mississippi University for Women 1100 College Street, MUW-1609 Columbus, MS 39701-5800		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
SIC CODE	EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION # PHONE #

## CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)  Mississippi Institutions of Higher Learning Self-Insured Workers' Compensation Plan	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
	TO	Cannon Cochran Management Services Incorporated P.O. Box 1378 Ridgeland, MS 39158-1290 601-899-0160 (fax)
<input type="checkbox"/> CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE		

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
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AGENT NAME & CODE NUMBER

## EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX		MARITAL STATUS		OCCUPATION/JOB TITLE
	<input type="checkbox"/> MALE (M)	<input type="checkbox"/> FEMALE (F)	<input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U)	<input type="checkbox"/> MARRIED (M)	EMPLOYMENT STATUS
PHONE	# OF DEPENDENTS	<input type="checkbox"/> SEPARATED (S)	<input type="checkbox"/> UNKNOWN (K)	NCCI CLASS CODE	
RATE	PER: <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER:	#DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
			DID SALARY CONTINUE?	<input type="checkbox"/> YES <input type="checkbox"/> NO	

## OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	<input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE		
COUNTY WHERE 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 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(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	<input type="checkbox"/> YES <input type="checkbox"/> NO
		WERE THEY USED?	<input type="checkbox"/> YES <input type="checkbox"/> NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT
		NO MEDICAL TREATMENT (0) <input type="checkbox"/>
		MINOR: BY EMPLOYER (1) <input type="checkbox"/>
		MINOR CLINIC/HOSP (2) <input type="checkbox"/>
		EMERGENCY CARE (3) <input type="checkbox"/>
		HOSPITALIZED > 24 HRS (4) <input type="checkbox"/>
		FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) <input type="checkbox"/>

WITNESSES (NAME & PHONE #)	DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER
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# WORKERS' COMPENSATION - FIRST REPORT OF INJURY EMPLOYER'S INSTRUCTIONS

## GENERAL INFORMATION

**EMPLOYER (NAME & ADDRESS INCL ZIP)** - The name and address of the entity employing or statutorily responsible for the employee.

**SIC CODE** - The code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

**EMPLOYER FEIN** - Employer's Federal Employer Identification Number

**CARRIER/ADMINISTRATOR CLAIM NUMBER** - Carrier's claim or file number.

**REPORT PURPOSE CODE** - A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

**JURISDICTION** - State in which you are filing the claim (Mississippi).

**JURISDICTION CLAIM NUMBER** - Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

**INSURED REPORT NUMBER** - The number, if any, used by the employer to identify the claim.

**EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)** - The name and address of the employer's facility where the employee was employed at the time of injury, if different from above.

**LOCATION #/ PHONE #** - The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

**CARRIER (NAME, ADDRESS & PHONE NO)** - The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

**POLICY PERIOD** - The date that the contract/policy under which the claim occurred began and expired.

**CHECK IF APPROPRIATE (SELF-INSURANCE)** - An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

**CLAIMS ADMINISTRATOR** - The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

**CARRIER FEIN** - Carrier's Federal Employer Identification Number.

**POLICY/ SELF-INSURED NUMBER** - The number assigned by the carrier to the insurance contract/policy for the employer; or any similar number assigned to a selfinsured employer.

**ADMINISTRATOR FEIN** - Federal Employer Identification Number of Administrator.

**AGENT NAME & CODE NUMBER** - The name of the insurance agent and the agent's code number if known. This information should be found in the insurance policy.

## EMPLOYEE/WAGE INFORMATION

**NAME (LAST, FIRST MIDDLE)** - Employee's legally recognized name.

**ADDRESS** - The mailing address used by the employee.

**PHONE** - A telephone number where the employee can be reached.

**DATE OF BIRTH** - The date the employee was born.

**SOCIAL SECURITY NUMBER** - A number assigned by the Social Security Administration used to identify the employee.

**DATE HIRED** - The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

**STATE OF HIRE** - State where employee was hired.

**SEX** - The code which indicates the sex of the employee.

**MARITAL STATUS** - The code which indicates the marital status of the employee.

**OCCUPATION/JOB TITLE** - This is the primary occupation of the employee at the time of the accident or exposure.

**EMPLOYMENT STATUS** - Indicate the employee's work status. The valid choices are: Full-time, Part-Time, Not Employed, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-Time, Apprenticeship Part-Time, Volunteer, Seasonal, or Piece Worker.

**NCCI CLASS CODE** - A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE.

**RATE** - The reported employee's wage rate at the time of injury.

**# DAYS WORKED/ WEEK** - The number of days worked by the employee in a week.

**FULL PAY FOR DAY OF INJURY** - State whether employee was paid his full wages on the injury date.

**DID SALARY CONTINUE** - State whether employee's salary was continued by the employer in lieu of compensation benefits.

## OCCURRENCE/TREATMENT INFORMATION

**TIME EMPLOYEE BEGAN WORK** - The time employee began work on date of injury.

**DATE OF INJURY/ILLNESS** - The date employee was injured.

**TIME OF OCCURRENCE** - The time employee was injured.

**LAST WORK DATE** - The date employee last worked following the injury.

**DATE EMPLOYER NOTIFIED** - The date on which the employer was notified of the injury.

**DATE DISABILITY BEGAN** - The date on which employee began losing time.

**CONTACT NAME/PHONE NUMBER** - Name and phone number of employer representative to be contacted for further information.

**TYPE OF INJURY/ILLNESS** - Briefly describe the nature of the injury or illness, (e.g., Lacerations to the forearm).

**PART OF BODY AFFECTED** - Indicate the part of body affected by the injury/illness, (e.g., Right Forearm, lower back).

**DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES** - Mark yes or no as applicable.

**TYPE OF INJURY/ILLNESS CODE** - The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

**PART OF BODY AFFECTED CODE** - The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

**COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED** - The county where the injury occurred. If the injury did **not** occur in Mississippi, put "out of state".

**ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED** - List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint. Enter "NA" for not applicable if no equipment, materials, or chemicals were being used.

**SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED** - Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

**WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED** - Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g., walking along a hallway).

**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** - Describe how the injury or illness/abnormal health condition occurred.

Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

**CAUSE OF INJURY CODE** - The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

**DATE RETURN(ED) TO WORK** - Enter the date following the most recent disability period on which the employee returned to work.

**IF FATAL, GIVE DATE OF DEATH** - Date of death of employee.

**WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED/WERE THEYUSED** - Check applicable "yes" or "no" box.

**PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS)** - The name and address of the physician or health care professional providing initial treatment.

**HOSPITAL (NAME AND ADDRESS)** - The name and address of the hospital where employee was treated (if applicable).

**INITIAL TREATMENT** - Check applicable choices.

**WITNESSES (NAME & PHONE #)** - The name(s) and phone number(s) of any one who witnessed the accident.

**DATE ADMINISTRATOR NOTIFIED** - The date the carrier or claims administrator processing the claim received notice of the injury.

**DATE PREPARED** - The date this report was prepared.

**PREPARER'S NAME & TITLE** - The name and title of the person who prepared this report.

**PHONE NUMBER** - The phone number of the person who prepared this report.

**Any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under this chapter (Mississippi Workers' Compensation Law) is guilty of a felony and on conviction thereof may be punished by a fine not to exceed Five Thousand (\$5,000) or double the value of the fraud, whichever is greater, or by imprisonment not to exceed three (3) years, or by both fine and imprisonment.**