

# IDF - Injury, Illness, Incident Data Form (replaces First Report of Injury or FRI)



**Instructions: This form is for the collection and reporting of data associated with a work-related, injury, illness or incident.** Supervisors must complete this entire form and submit either by email (preferred method) or signed paper copy to the Agency Workers' Compensation Coordinator within 24 hours of receiving notice of the injury, illness or incident. **Do not email directly from web site. Save completed form to your computer, then email.** Supervisors should immediately contact CorVel (the state's workers' compensation managed health care system) at 612-436-2542 or 1-866-399-8541, if an injured employee is admitted to an overnight stay at a hospital or requires immediate surgery on day of injury. **Please contact your agency/facility's Workers' Compensation Coordinator with any questions.** Checklists, forms, and more information are available at: <http://www.risk-workerscomp.admin.state.mn.us/forms.htm>

## Incident Details

1. Date of incident: (MM/DD/YY)	2. Time of incident: <input type="checkbox"/> am <input type="checkbox"/> pm	3. Date reported: (MM/DD/YY)	4. Time reported: <input type="checkbox"/> am <input type="checkbox"/> pm	5. Incident type: <input type="checkbox"/> Incident <input type="checkbox"/> Injury - no lost time <input type="checkbox"/> Injury - lost time <input type="checkbox"/> Property damage
6. Description of incident: (limited to 250 characters, be sure to include detail about the body part, cause, and nature of injury) For example: "worker developed soreness in left wrist over time doing computer work" or "slipped and fell on wet floor breaking right leg"				7. Chemical, tools, equipment, or items involved: (e.g. "boxes")
				8. Specific body part:
9. Employer/Agency:	10. Facility/Location:	11. Division:	12. Exact location of incident:	
13. Incident reported to (full name):	14. Emp/State ID#:	15. Work phone: ( )	16. Has incident investigation been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Person reporting incident (full name):	18. Emp/State ID#:	19. Work phone: ( )	20. Incident result in fatality? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter date:	
21. Is there a witness to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Witness's full name (if more than one please attach separate page):		23. Witness's phone: ( )	
24. Did incident involve travel? <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Was a state vehicle damaged? <input type="checkbox"/> Yes <input type="checkbox"/> No	26. Motor vehicle accident report completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		

## Injury/Illness Details

27. Injured person's employment status (If contract worker please stop here) <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Student <input type="checkbox"/> Intern <input type="checkbox"/> Contract worker				
28. First name of injured person:	29. Middle initial:	30. Last name:		
31. Emp/State ID #:	32. Work phone: ( )	33. Home phone: ( )	34. Start time day of injury: <input type="checkbox"/> am <input type="checkbox"/> pm	
35. Work shift (e.g. M-F 8:00am-4:30pm):	36. Does employee have second job? <input type="checkbox"/> Yes <input type="checkbox"/> No	37. Second employer name:	38. 2 <sup>nd</sup> job gross weekly income:	
39. Has injured employee missed work due to injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	40. First date employee missed work:	41. Date employee last at work:	42. Missed work on day of injury due to injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of hours:	
43. Date employer notified of lost time:	44. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	45. Date returned to work:		
46. Was medical treatment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	47. Emergency room visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	48. Hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No		
49. Medical facility's name: (if no medical treatment please respond "None")		50. Medical facility's address:		
51. Treating physician's name: (if no medical treatment please respond "None")	52. Physician's phone: ( )	53. Treating physician's address (if different than facility):		

## Supervisor/Designee Certification

54. Supervisor/Designee name:	55. Emp/State ID#:	56. Work phone: ( )	57. Signature:	58. Date:
-------------------------------	--------------------	------------------------	----------------	-----------

Insurer: Minnesota Dept. of Administration, Risk Management Division, Workers' Compensation Program P.O. Box 64081, St. Paul, MN 55164-0081 Phone (651) 201-3000	For agency use:	Claimant Name _____ Date entered into SEMA4: _____
		Date of Incident: _____ Entered by: _____
Injury/illness/incident Data Form rev. 3/1/09		WC Claim #: _____ SEMA4 Incident #: _____
		WC Claim Specialist _____
		Agency hire date: _____ WC Location Code: _____