WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

9/11/2019-SC

EMPLOYER NAME, ADDRESS, ZIP	CARRIER/ADMINSTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
TANGIPAHOA PARISH SCHOOL SYSTEM **59656 PULESTON ROAD** **AMITE, LA 70422**	JURISDICTION	JURISDICTION CLAIM NUMBER	INSURED REPORT NUMBER
PHONE **985-748-7153**	INJURY LOCATION NAME_____ ADDRESS_____		
INDUSTRY CODE			
EMPLOYER FEIN	ADDRESS _____ PHONE_____		

CARRIER CLAIMS ADMINISTRATOR

CARRIER (NAME & ADDRESS)	POLICY PERIOD:	CLAIMS ADMINISTRATOR (NAME & ADDRESS)
CAS-CLAIMS AMINISTRATIVE SERVICES, INC. **501 SHELLY DRIVE** **TYLER, TX 75701**	FROM: _____ TO: _____	**CAS-CLAIMS ADMINISTRATIVE SERVICES, INC.** **501 SHELLY DRIVE** **TYLER, TX 75701**
PHONE **1-800-765-2412**	☐ SELF INSURANCE (CHECK IF APPROPRIATE)	PHONE **1-800-765-2412**

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

AGENT NAME	AGENT PHONE	AGENT EMAIL
MELINDA BOYD	**1-800-765-2412 EXT. 75752**	**Melinda.Boyd@cas-services.com**

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE):

_____

ADDRESS:

_____

_____

DATE HIRED_____ STATE OF HIRE: Louisiana DRIVERS LICENSE# _____

DATE OF BIRTH: _____ SEX: ____MALE ____FEMALE ____UNKNOWN NUMBER OF DEPENDANTS: _____

MARITAL STATUS: _____ MARRIED _____SEPARATED _____UNMARRIED/SINGLE/DIVORCED _____UNKNOWN

SOCIAL SECURITY # _____PHONE: _____

OCCUPATION/JOB TITLE: _____

EMPLOYMENT STATUS_____ # OF DAYS WORKED PER WEEK; _____

RATE OF PAY: $_____ *PER* _____DAY _____WEEK _____MONTH _____OTHER

FULL PAY FOR DATE OF INJURY? _____YES _____NO DID SALARY CONTINUE? _____YES _____NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE: _____ ☐ A.M. ☐ P.M.	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
_____ ☐ A.M. ☐ P.M.		☐ CANNOT BE DETERMINED			

CONTACT NAME & PHONE	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ____YES ____NO	CODE: TYPE OF INJURY/ILLNESS	CODE: PART OF BODY AFFECTED	CODE: CAUSE OF INJURY
DEPARTMENT OR LOCATION WHERE ACCIDENT/ILLNESS/EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, AND/OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT/ILLNESS/EXPOSURE OCCURRED		

SPECIFIC ACTIVITY EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT/ILLNESS/EXPOSURE OCCURRED	WORK PROCESS EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT/ILLNESS/EXPOSURE OCCURRED

HOW THE INJURY/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 RETURNED TO WORK	IF FATAL, DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ____YES ____NO WERE THEY USED? _____YES ____NO

NAME/ADDRESS OF PHYSICIAN/HEALTH CARE PROVIDER (IF KNOWN)	NAME/ADDRESS OF HOSPITAL/OFF-SITE TREATMENT (IF KNOWN)	INITIAL TREATMENT: _____NO MEDICAL TREATMENT _____ EMERGENCY CARE _____MINOR *(BY EMPLOYER)* _____HOSPITALIZED >24 HOURS _____MINOR *(CLINIC/HOSPITAL)* _____FUTURE MAJOR MEDICAL *(LOST TIME ANTICIPATED)*

OTHER

WITNESS NAME: _____ PHONE: _____

WITNESS NAME: _____ PHONE: _____

*SUPERVISOR'S SIGNATURE*_____

SUPERVISOR'S TITLE_____

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME/TITLE	PHONE NUMBER