South Dakota Employer's First Report of Injury

(See Instructions on Back of Form)

EMPLOYEE

SSN: _____ Date of Birth: _____ Gender: M ☐ F ☐ # Dependents: _____

Name: _____
(Last) (First) (Middle initial)

Mailing Address: _____

City: _____ State: _____ Zip: _____ Telephone No.: _____

Employee signature: (X) _____ Date _____

Education:

☐ Less than High School
☐ GED or High School
☐ Beyond High School

INJURY/TREATMENT

Date of Injury: _____ Time of Injury: _____ a.m./p.m. Fatality Date (if applicable): _____

County Where Injury Occurred: _____ Was Safety Equipment Provided? Yes ☐ or No ☐

Time Work Day Began on Date of Injury: _____ a.m./p.m. Was Safety Equipment Used? Yes ☐ or No ☐

Date Returned to Work (if applicable): _____ Did Injury Occur on Employer Premises? Yes ☐ or No ☐

Address or Location of Injury: _____

Description of Injury: _____

_____

Date Employer Notified of Injury: _____

Injury Reported to: _____ Witness: _____

(See Codes on Reverse)

_____ Body Part Injured

(If code 90, Multiple Injury, please specify body part codes for each body part injured.)

_____ _____

_____ _____

_____ Nature of Injury

_____ Cause of Injury

Type of Treatment (please check one)

☐ No Treatment
☐ On-Site Treatment
☐ Clinic
☐ Emergency Room
☐ Hospitalization

If treatment sought, please specify provider of treatment:

Doctor, Clinic or Hospital Name: _____

Mailing Address: _____

City: _____ State _____ Zip _____

Telephone No. : _____

EMPLOYER/EMPLOYMENT INFORMATION:

Federal ID No.: _____ # Employees: _____

Employer Name (DBA): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone No. : _____ County Where Employer Located: _____

Employer signature: _____ Date _____

Employment Type: ☐ Regular or ☐ Temporary

Emp. Status: ☐ FT ☐ PT ☐ Seasonal ☐ Volunteer

Date Employee Hired: _____

Employee's Position: _____

Employee's Time in Current Position: _____

Employee's Hours Per Week: _____

Employee's Current Wage:

$ _____ per _____

CLAIM OFFICE INFORMATION

NAICS for Employer Being Insured (Nature of Business): _____

Carrier Code _____ FEIN (Claim Office) _____

Claim Office _____

Claim Office Address _____

City _____ State _____ ZipCode _____

Telephone _____

Email Address _____

Claim Office Claim # _____

Date Notified _____ Date to DOL _____

☐ Check if Claim Office is same as Insurance Provider

If not, you must complete the following
UNDERLYING INSURANCE PROVIDER INFORMATION

Carrier Code (If applicable) _____

FEIN (Insurance Provider) _____

Represented Entity Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

Policy Number _____

Effective Dates _____

Adjuster / Contact Person _____

Submit form to: South Dakota Department of Labor
Division of Labor and Management
700 Governors Drive
Pierre, SD 57501-2291
Telephone (605) 773-3681

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