Reference No:

Central Office use only:
Incident No:

Claim No:

DAS
First Report of Injury WC 207

The Supervisor must complete this form with the employee and then forward it to your Agency's Workers' Compensation specialist within 24 hours after the incident.

1. AgencyLocationCode	2. Division/Region			
3.SSN	4.Employee Number	5.Name of Injured Worker *(First) (Last) (MI)*		
6.Home Address (City or Town) (State) (Zip)		7.Home Telephone	8.Date of Birth	9.Sex
10.Job Classification		11. Date of Hire	12.Date of Incident	13.Time of Incident
14.Time Employer Notified	15.Date Employer Notified	16. Was Injury Fatal? YES NO	17. Date of Fatality	
18. How Did the Injury Occur?				
19. Type of Injury	20. Body Part(s) Affected	21. Category of Illness or Injury		
22. Did Injury Occur on Employer Premises? ☐ YES ☐ NO	23. Location Injury Occured			
24. Injured Worker Seeking Medical Treatment ☐ YES if yes complete question 24 ☐ NO	25. Medical Care Provided By: (Physician Name and Address)			
26. Were There Any Witnesses to the Injury? (If yes, give name, address and phone.)				
27. To Whom Was Injury Reported? (Name) (Title)				

28. SUPERVISOR CONTACT INFO Please print	Name: Work Phone: Best Time to Contact:
29. Signature of Supervisor (or other Designated Authority)	

I HAVE REVIEWED THE ABOVE FORM FOR COMPLETENESS

SUPERVISORS REPORT ALL INJURIES - CALL 1-800-828-2717

white agency copy *yellow* agency copy *pink* employee copy