

South Dakota Employer's First Report of Injury

(See Instructions on Back of Form)

E M P L O Y E E	SSN: _____ Date of Birth: _____ Gender: M <input type="checkbox"/> F <input type="checkbox"/> # Dependents: _____ Name: _____ (Last) _____ (First) _____ (Middle initial) Mailing Address: _____ City: _____ State: _____ Zip: _____ Telephone No.: (____) _____ Employee signature: (X) _____ Date _____	Education: <input type="checkbox"/> Less than High School <input type="checkbox"/> GED or High School <input type="checkbox"/> Beyond High School
I N J U R Y / T R E A T M E N T	Date of Injury: _____ Time of Injury: _____ a.m./p.m. Fatality Date (if applicable): _____ County Where Injury Occurred: _____ Was Safety Equipment Provided? Yes <input type="checkbox"/> or No <input type="checkbox"/> Time Work Day Began on Date of Injury: _____ a.m./p.m. Was Safety Equipment Used? Yes <input type="checkbox"/> or No <input type="checkbox"/> Date Returned to Work (if applicable): _____ Did Injury Occur on Employer Premises? Yes <input type="checkbox"/> or No <input type="checkbox"/> 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) <input type="checkbox"/> No Treatment <input type="checkbox"/> On-Site Treatment <input type="checkbox"/> Clinic <input type="checkbox"/> Emergency Room <input type="checkbox"/> 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: <input type="checkbox"/> Regular or <input type="checkbox"/> Temporary Emp. Status: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Seasonal <input type="checkbox"/> 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 _____ Zip Code _____ Telephone _____ Email Address _____ Claim Office Claim # _____ Date Notified _____ Date to DOL _____	<input type="checkbox"/> 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