

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known)
1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)

2a. LOST TIME - ONE OR MORE DAYS	2b. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY?	YES	NO
3. LOST EARNINGS BUT NO LOST TIME	4. MEDICAL/HEALTH CARE	5. FATALITY DATE OF DEATH:	
6a. OCCUPATIONAL DISEASE	6b. DATE OF LAST EXPOSURE:	6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED:	
7a. CORRECT PRIOR REPORT	7b. DATE OF CORRECTION:	7c. DATE CORRECTION SENT TO WCB:	

EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):	10. EMPLOYER NAME:		
11. STREET/P.O. BOX MAILING ADDRESS:	12. CITY:	13. STATE:	14. ZIP:	15. TELEPHONE NUMBER:
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:	18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:		

(check one)

INSURER

THIRD PARTY ADMINISTRATOR (TPA)

SELF-ADMINISTERED EMPLOYER

19. INSURANCE / TPA COMPANY NAME:	20. POLICY NUMBER:	21. INSURER FILE NUMBER:		
22. STREET/P.O. BOX MAILING ADDRESS:	23. CITY:	24. STATE:	25. ZIP:	26. TELEPHONE NUMBER:

EMPLOYEE

27. LAST NAME:	28. FIRST NAME:	29. MI:	30. TELEPHONE NUMBER:	31. SOCIAL SECURITY NUMBER:	32. GENDER: MALE FEMALE
33. STREET/P.O. BOX MAILING ADDRESS:	34. CITY:	35. STATE:	36. ZIP:	37. DATE OF BIRTH:	
38. OCCUPATION/JOB TITLE:	39. DATE OF HIRE:	40. WEEKLY WAGE AT TIME OF INJURY: \$	41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? YES NO IF YES, GIVE NAME AND ADDRESS:		

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS:	43. DATE OF INCAPACITY:	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.):	45. DATE EMPLOYER NOTIFIED INSURER/TPA:		
DATE EMPLOYER NOTIFIED:	DATE EMPLOYER NOTIFIED:	46. TIME OF INJURY (e.g. 1:10 p.m.):	47. HAS EMPLOYEE RETURNED TO WORK? YES NO IF YES, GIVE DATE:		
48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	49. BODY PART(S) AFFECTED (e.g. lower right forearm):	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):			

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring):	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):				
WAS ACTIVITY PART OF NORMAL JOB DUTIES? YES NO					

53. HOSPITALIZED OVERNIGHT AS INPATIENT? YES NO	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? YES NO	55. HEALTH CARE PROVIDER NAME:	56. MAILING ADDRESS:	57. TELEPHONE NUMBER:
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PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OR PRINT):	59. TELEPHONE NUMBER:	60. DATE SENT TO WCB:
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THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY Maine Relay 711.

W CB-1 (eff. 1/1/13)