DAS WC-207

First Report of Injury

Rev 02/2017

TPA Reference No.	Agency use only Incident No.:
	Claim No.:

The Supervisor must complete this form with the injured worker and then forward it along with the balance of the claim forms to the Human Resources/Workers' Compensation Office within 24 hours.

1. Agency Location Code	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 (Title)		11. Date of Hire	12. Date of Incident	13. Time of Incident
14. Time Employer Notified	15. Date Employer Notified	16. Time Injured Worker Began Work ______ ☐AM ☐PM	17. Was Injury Fatal? ☐ YES ☐ NO	18. Date of Fatality
19. How Did the Injury Occur?				
20. Type of Injury		21. Body Part(s) Affected		
22. Did Injury Occur on Employer Premises? ☐ YES ☐NO		23. Location Injury Occurred		
24. Injured Worker Seeking Medical Treatment ☐ YES ☐ NO If Yes Complete Questions 25-27		25. Medical Care Provided By: (Physician Name and Address)		
26. Was Injured Worker Treated in an Emergency Room? ☐ YES ☐ NO		27. Was Injured Worker Hospitalized Overnight as an In-Patient? ☐ YES ☐ NO		
28. Were There Any Witnesses to the Injury? ☐YES ☐NO (If yes, give name, address, and phone)				
29. To What Supervisor Was Injury Reported? (Name) (Title)				

30. Supervisor Contact Info Please Print	Name:
	Work Phone:
	Best Time to Contact:

31. **Signature of Supervisor** (or other Designated Authority)	**PRINT NAME:**	**DATE:**
32. **Date Injury Phoned In To 800-828-2717**		

Supervisors Report All Injuries - Call 1-800-828-2717