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