FIRST REPORT OF INJURY

CLAIMS DIVISION
SFN 2828 (11/2017)

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Toll Free Fax 888-786-8695
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Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

SECTION 1 - *Completion of this section is required*

Claim number	Worker's (First name)	(Last name)	Social Security number*
Date of birth	Gender ☐ Female ☐ Male	Marital status ☐ Single ☐ Married	Worker's telephone number
Worker's physical address (Street address)			
City		State	ZIP code
Worker's mailing address, if different than physical address (Street address, PO Box number)			
City		State	ZIP code
Date of injury	Time of injury ☐ AM ☐ PM	Nature of injury or illness (broken left leg, carpal tunnel left wrist, etc.)	
Body parts injured (Example: 2nd/middle finger, shoulder, ankle, etc.) ☐ Left ☐ Right ☐ NA			
How did the injury happen?			
Has this claim been filed in another state? ☐ Yes ☐ No If yes, which state?			
Where did the injury happen? (City)	(County)	(State)	
Treating doctor's name			Date of first treatment ☐ NA
Clinic/hospital name (If you have received treatment in more than one location, please provide the name of clinic/hospital, treating doctor(s), address and telephone number of all locations on page two or separate sheet of paper.)			
Clinic/hospital mailing address (Street address, PO Box number)			Clinic/hospital telephone number
City	State		ZIP Code
Employer's name			Employer's telephone number
Employer's mailing address	City	State	ZIP code
What is the worker's job?	Date hired (Month) (Year)		Last day worked in ND prior to injury

SECTION 2 – *Worker completion*

Date employer notified	Person you notified	Before this injury, have you had any problems, injuries, or treatment to the injured body parts? ☐ Yes ☐ No
Have you missed or will you miss 5 or more consecutive days of work due to the injury? **OR** Has a doctor taken you off work for 5 or more consecutive days? ☐ Yes ☐ No		
Witness to the injury (First name)	(Last name)	Telephone number

SECTION 3 – *Release of information/fraud warning/signature*

Release of information

I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including all prior records as well as those pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS-related illness. I authorize healthcare providers to respond to WSI regarding my injury, including request for conclusions and opinions not otherwise contained within existing medical records.

(Continued on page 2)

Claim number	Worker's (First name)	(Last name)

In addition, I authorize any education agency or institution to release to WSI any and all "educational records" as defined by 20 U.S.S 21 Sec. 1232g. This authorization continues while I have any claim open or pending before WSI. WSI is exempt from HIPAA regulations. I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.

Fraud warning
Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for workers' compensation benefits will forfeit any future benefits and may be guilty of a felony which is punishable by imprisonment, substantial fines, or both. These criminal penalties are applicable to all persons dealing with WSI, including injured workers, employers, medical providers, and attorneys.

Signature
By signing this form, I acknowledge that I have read and understand the release of information and fraud warning. I understand that falsifying this claim or making a false statement regarding this claim may be a felony, punishable by substantial fines and imprisonment. I authorize the release of information and agree that statements in this form are true and accurate.

Worker's signature	**Date signed**

In addition to myself, I authorize WSI to release information on my claim to (please print)
First name Last name Relationship

SECTION 4 - *Employer completion*

Employer's account number	Rate class	Is worker a corporate officer, owner, or family member? ☐ Yes ☐ No
Employer's name	Mailing address (Street address, PO Box number)	
City	State	ZIP code

Has the worker missed or will they miss 5 or more consecutive days of work due to the injury? **OR** Has a doctor taken the worker off work for 5 or more consecutive days? ☐ Yes ☐ No

Date employer notified	Person notified	Before this injury, are you aware of the worker having any problems, injuries, or treatment to the injured body part? ☐ Yes ☐ No ☐ Unknown

Do you have a Designated Medical Provider (DMP)? ☐ Yes ☐ No	Did the worker add another medical provider? ☐ Yes ☐ No If yes, which provider?	Do you question this claim? ☐ Yes ☐ No If yes, please explain in section 5.

Employer's signature	**Title**	**Date signed**

SECTION 5 – *Additional information or comments*

* In compliance with the Federal Privacy Act of 1974, disclosure of the Social Security number on this form is mandatory pursuant to N.D.C.C. § 65-05-02. The Social Security number is used for identification and verification purposes. Failure to provide this information may result in a delay in processing your request.

To report an instance of fraud, contact the ND Fraud and Safety Hotline at 800-243-3331.