

SOUTH DAKOTA EMPLOYER'S FIRST REPORT OF INJURY

(SEE INSTRUCTIONS ON BACK OF FORM)

| | | | |
|--|--|---|---|
| | 1 Social Security Number | 2 Date of Injury | 3 Date of Birth |
| EMPLOYEE INFORMATION | 4 Last Name, First Name, Middle Initial | | 5 Education (circle one) Less than High School GED or High School Beyond High School |
| | 6 Home Address | | 7 Sex (circle one) Male Female 8 Dependents |
| EMPLOYEE INFORMATION | 9 City, State, Zip Code | | 10 Telephone Number |
| | 11 Position Title | 12 Employment Type (circle one) Regular Temporary | 13 Employment Status (circle one) Full Time Part Time Seasonal Volunteer |
| | 14 Current Wage \$ _____ per | 15 Hours Per Week | 16 Time in Current Position 17 Date Hired |
| 18 Injury Description (select codes from the back of form for the following) A. Body Part Injured <input type="text"/> <input type="text"/> B. Cause of Injury <input type="text"/> <input type="text"/> C. Nature of Injury <input type="text"/> <input type="text"/> Describe Injury Below | | | |
| INJURY INFORMATION | 19 Address or Location of Injury | | |
| | 20 Time of Injury <input type="checkbox"/> AM <input type="checkbox"/> PM | 21 Time Work Day Began <input type="checkbox"/> AM <input type="checkbox"/> PM | 22 Date Employer Notified |
| | 23 Reported to | 24 Witness | |
| | 25 Return to Work Date | 26 Date of Fatality | 27 Safety Equipment Provided? Yes or No Was Safety Equipment Used? Yes or No |
| 28 Doctor, Clinic, or Hospital Name (if treated) | | 29 Telephone Number | |
| 30 Address | | 31 Type of Treatment (circle one) No Treatment On-site Treatment | |
| 32 City, State, Zip Code | | Clinic Emergency Room Hospitalization | |
| 33 Employee's Signature | | Date | |
| EMPLOYER INFORMATION | 34 Federal Identification Number | 35 Number of Employees | 36 Type of Business |
| | 37 Business Name | | 38 Telephone Number |
| | 39 Address | | 40 Date Mailed to Insurance Company |
| | 41 City, State, Zip Code | | 42 Form Completed by |
| | 43 Employer's Signature | | Date |
| INSURANCE INFORMATION | 44 NAIC Number | 45 Insurance Claim Office | 46 Telephone Number |
| | 47 Address | | 48 Insurance Adjuster |
| | 49 City, State, Zip Code | | 50 Insurance Claim Number |
| | 51 Policy Number and Effective Dates | | 52 Date Insurer Mailed to DOL |

GENERAL INSTRUCTIONS

EMPLOYEE:

1. Notify employer immediately of injury.
2. Complete all questions in the employee information and injury information sections.
3. Sign the form.
4. Submit this form to your employer within three (3) business days after the injury.

EMPLOYER:

1. Complete all questions in the employer information section.
2. Sign the form.
3. Submit this form to your workers' compensation insurance carrier within seven (7) days of knowledge of the occurrence of an injury.
4. Give a copy of the form to the injured employee.
5. Keep a copy of the First Report of Injury for at least four years from the date of injury as required by SDCL 62-6-1.

INSURER:

1. Complete all questions in the insurance information section at the bottom of the page.
2. Submit this form within ten (10) days of receipt to:
South Dakota Department of Labor
Division of Labor and Management
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3681

CODES FOR QUESTIONS #18

18A. Body Part Codes:

| | | | |
|------------------|----------------------|----------------|----------------------|
| 30 = Ankle | 02 = Finger (index) | 33 = Hip | 01 = Thumb |
| 09 = Arm | 05 = Finger (little) | 14 = Knee | 06 = Toe (greater) |
| 18 = Back | 03 = Finger (second) | 13 = Leg | 07 = Toe (other) |
| 35 = Chest | 04 = Finger (third) | 29 = Lungs | 10 = Wrist |
| 16 = Ear (one) | 12 = Foot | 25 = Mouth | 23 = Multiple Injury |
| 17 = Ears (both) | 34 = Groin | 27 = Neck | 24 = Other |
| 11 = Elbow | 08 = Hand | 31 = Ribs/Side | |
| 15 = Eye | 26 = Head | 28 = Shoulder | |
| 36 = Face | 21 = Heart | 32 = Stomach | |

18B. Cause of Injury Codes:

| | |
|----------------------------------|---------------------------|
| 11 = Bending/Lifting | 01 = Motor Vehicle |
| 08 = Body Reaction/Over Reaction | 10 = Repetitive Use |
| 06 = Caught In/Under/Between | 12 = Stress |
| 03 = Fall From Elevation | 05 = Struck Against |
| 04 = Fall From Same Level | 07 = Struck By |
| 09 = Hostile Attack | 02 = Temperature Extremes |
| 14 = Knife/Sharp Object | 13 = Other |
| 15 = Machinery/Equipment | |

18C. Nature of Injury Codes:

| | | |
|--------------------|---------------------------|---------------------|
| 01 = Allergy | 03 = Hearing Loss | 05 = Not Applicable |
| 02 = Disfigurement | 04 = Occupational Disease | |