THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2
Rev. 10/2012

STATE OF ALABAMA

EMPLOYER'S FIRST REPORT OF INJURY

OR OCCUPATIONAL DISEASE

CLAIM REFERENCE

1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS
5. Physical Address 1	10. Mailing Address 1
6. Physical Address 2	11. Mailing Address 2
7. City 8. State 9. Zip	12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number	17. NAICS

INSURER / FILING OFFICE

18. Insurer Name	21. Filing Office Name
	22. Mailing Address 1
19. Insurer Federal ID Number	23. Mailing Address 2 or Telephone Number
	24. City 25. State 26. Zip
20. Type Insurer Ins Co ☐ Self-Insurer ☐ Group Fund ☐	27. Filing Office Federal ID Number

EMPLOYEE / WAGES

28. First Name	32. Employee ID Number
29. Middle Name	33. Type Employee ID Number
30. Last Name	SSN ☐ Passport Number ☐ Green Card ☐
31 Last Name Suffix (ie. Jr., Sr., III)	Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1	40. Gender Male ☐ Female ☐	41. Date of Birth
35. Mailing Address 2		
36. City 37. State 38. Zip 39. Phone		42.Nbr of Dependents

43. Marital Status Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐	44. Date Hired
45. Occupation Description	46. Number of Days Worked Per Week

47. Wages $	49. Received Full Pay For Day of Injury? Yes ☐ No ☐
48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐	50. Did Salary Continue? Yes ☐ No ☐

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE	61. Injury Occurred on Employer's Premises? Yes ☐ No ☐
56. Site Address	
57. City 58. State 59. Zip	62. Date Employer Notified
60. County	

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

67. Initial Treatment	No Medical Treatment ☐	68. Name of Treatment Facility
First Aid By Employer ☐	Minor Clinic / Hospital ☐	69. Address
Emergency Room ☐	Hospitalized Overnight ☐	70. City 71. State 72. Zip
Hospitalized > 24 Hours ☐	Outpatient Treatment ☐	

73. Name of Physician or Other Health Care Professional	74. Has Injured Returned to Work Yes ☐ No ☐	If so, 75. Date 76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name 79. Last Name 80. Title	81. Preparer's Telephone Number