

MN Department of Labor and Industry
 Workers' Compensation Division
 PO Box 64221
 St. Paul, MN 55164-0221
 (651) 284-5032 or 1-800-342-5354
 Fax: (651) 284-5731

First Report of Injury

See Instructions on Reverse Side.



F R O 1

DO NOT USE THIS SPACE

PRINT IN INK or TYPE
 ENTER DATES IN MM/DD/YYYY FORMAT

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. EMPLOYEE SOCIAL SECURITY # | | 2. OSHA Case # | | 3. Time employee began work on date of injury | | <input type="checkbox"/> am <input type="checkbox"/> pm | |
| 4. DATE OF CLAIMED INJURY | | 5. Time of injury | | 6. Date of death | | # of dependents (if death is related to injury) | |
| | | <input type="checkbox"/> am <input type="checkbox"/> pm | | | | | |
| 7. EMPLOYEE Name (last, suffix, first, middle) | | | | 8. Gender | | 9. Marital status | |
| | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | <input type="checkbox"/> Married <input type="checkbox"/> Unmarried | |
| 10. Home address | | | | 11. Home phone # | | 12. Date of birth | |
| 13. Date hired | | | | | | | |
| City | | State | | Zip Code | | 14. Occupation | |
| | | | | | | 15. Regular department | |
| | | | | | | 16. Apprentice <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 17. Average weekly wage | | 18. Rate per hour | | 19. Hours per day | | 20. Days per week | |
| | | | | | | Normal work schedule Sun – Sat S M T W T F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | |
| | | | | | | 21. Employment status (check all that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer | |
| 22. Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was. Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry." | | | | | | | |
| 23. What was the injury or illness (include the part(s) of body)? Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist. | | | | 24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. | | | |
| 25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No Name and address of the place of the occurrence | | | | 26. First date of any lost time | | 27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI | |
| | | | | 28. Date employer notified of injury | | 29. Date employer notified of lost time | |
| | | | | 30. Return to work date | | 31. RTW same employer <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | 32. RTW with restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 33. Treating physician(name) | | | | 34. Extent of medical treatment (check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Minor on-site by employer's medical staff <input type="checkbox"/> Minor clinic/hospital <input type="checkbox"/> Emergency room <input type="checkbox"/> Hospitalization more than 24 hours <input type="checkbox"/> Future major medical anticipated | | | |
| 35. Certified Managed Care Organization (if any) | | | | | | | |
| 36. EMPLOYER Legal name | | | | 37. EMPLOYER DBA name (if different) | | | |
| 38. Mailing address | | | | 39. Employer FEIN | | 40. Unemployment ID # | |
| City | | | | State | | Zip Code | |
| | | | | 41. Employer's contact name and phone # | | | |
| 42. Physical address (if different) | | | | 43. Witness (name and phone) – if more than 1 attach a separate sheet | | | |
| City | | | | State | | Zip Code | |
| | | | | 44. NAICS code | | 45. Date form completed | |
| 46. INSURER name League of Minnesota Cities Insurance Trust | | | | 51. CLAIMS ADMIN COMPANY (CA) name (check one) Berkley Risk Administrators Company, LLC <input type="checkbox"/> Insurer <input checked="" type="checkbox"/> TPA | | | |
| 47. Insured legal name and FEIN | | | | 52. CA Address 145 University Avenue West | | | |
| 48. Policy # (including effective dates) or self-insured certificate # | | | | City | | State | |
| | | | | St. Paul | | MN | |
| | | | | | | Zip Code | |
| | | | | | | 55103-2044 | |
| 49. Insurer FEIN 41-6007047 | | 50. Date insurer received notice | | 53. CA FEIN 0698639002 | | 54. CA Claim # | |
| 55. To be completed by the CA: | | Claim type code: | | Type of loss code: | | Late reason code: | |
| | | | | | | Salary paid in lieu of comp? | |
| | | | | | | Death result of injury? | |

LM 2510 (1/17)

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov.

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see www.usa.gov/Business/Business-Gateway.shtml and click on "Get an Employer ID Number".
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR (For first reports of injury filed on or after Jan. 1, 2014)

Pursuant to Minnesota Statutes, section 176.231, and Minnesota Rules, part 5220.2530, insurers and self-insured employers must file with the Department's Workers' Compensation Division an electronic first report of injury, according to the requirements set out in sections 2 to 4 of the Minnesota implementation guide, in all cases where a first report of injury is required to be filed under Minnesota Statutes, chapter 176. The Minnesota implementation guide can be found on the Department's website at www.dli.mn.gov/WC/Edi.asp.

A first report of injury submitted by the insurer or self-insured employer in any other manner or format is not considered filed with the division, except for a written first report of injury on a paper form filed by a self-insured employer within seven days of death or serious injury.

If the claim does not involve lost time beyond the waiting period or potential permanent partial disability (PPD), or has not been requested to be filed by the Department, a first report of injury does **not** need to be filed.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.