

TPA Reference No.		Agency use only Incident No.:		<h1>DAS</h1> <h1>WC-207</h1> <h2><i>First Report of Injury</i></h2>	
		Claim No.:			
The Supervisor must complete this form with the injured worker and then forward it along with the balance of the claim forms to the Human Resources/Workers' Compensation Office within 24 hours. Rev 02/2017					
1. Agency Location Code		2. Division/Region			
3. SSN		4. Employee Number	5. Name of Injured Worker (First) (Last) (MI)		
6. Home Address (City or Town) (State) (Zip)			7. Home Telephone	8. Date of Birth	9. Sex
10. Job Classification (Title)			11. Date of Hire	12. Date of Incident	13. Time of Incident
14. Time Employer Notified		15. Date Employer Notified	16. Time Injured Worker Began Work _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	17. Was Injury Fatal? <input type="checkbox"/> YES <input type="checkbox"/> NO	18. Date of Fatality
19. How Did the Injury Occur?					
20. Type of Injury			21. Body Part(s) Affected		
22. Did Injury Occur on Employer Premises? <input type="checkbox"/> YES <input type="checkbox"/> NO			23. Location Injury Occurred		
24. Injured Worker Seeking Medical Treatment <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes Complete Questions 25-27			25. Medical Care Provided By: (Physician Name and Address)		
26. Was Injured Worker Treated in an Emergency Room? <input type="checkbox"/> YES <input type="checkbox"/> NO			27. Was Injured Worker Hospitalized Overnight as an In-Patient? <input type="checkbox"/> YES <input type="checkbox"/> NO		
28. Were There Any Witnesses to the Injury? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, give name, address, and phone)					
29. To What Supervisor Was Injury Reported? (Name) (Title)					
30. Supervisor Contact Info Please Print		Name:			
		Work Phone:			
		Best Time to Contact:			
31. Signature of Supervisor (or other Designated Authority)			PRINT NAME:		DATE:
32. Date Injury Phoned In To 800-828-2717					