



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

REPORT OF INJURY

P.O. BOX 58
JEFFERSON CITY, MO 65102-0058

(To complete form, see attached instructions)

GENERAL	EMPLOYER (NAME, ADDRESS, INCL ZIP CODE) Jefferson Franklin Community Action Corp P.O. Box 920 Hillsboro, MO 63050		CARRIER ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE					
	SIC CODE		EMPLOYER FEIN 43-0827872		PHONE #					
	JURISDICTION MO		JURISDICTION CLAIM NUMBER							
	INSURED REPORT NUMBER									
EMPLOYERS LOCATION ADDRESS (IF DIFFERENT)			LOCATION #							
CARRIER CLAIMS ADMIN	CARRIER (NAME, ADDRESS & PHONE NO.) MRSWCIT 1913 Southridge P.O. Box 10468 Jefferson City, MO 65110-4268		POLICY PERIOD to		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.) CCMSI 111 So.11th Street, Suite 430 St. Louis, MO 63102 Fax: 341-621-0345					
	CARRIER FEIN		INSURANCE POLICY NUMBER		ADMINISTRATOR FEIN 37-1057804					
	CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE									
	AGENT NAME & CODE NUMBER									
EMPLOYEE	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY #	DATE HIRED	STATE OF HIRE				
	ADDRESS (INCLUDE ZIP)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		OCCUPATION JOB TITLE				
	PHONE #		# OF DEPENDENTS		EMPLOYMENT STATUS		NCCI CLASS CODE			
	RATE PER <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER		# OF DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
OCCURRENCE	TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM		DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN			
	CONTACT NAME PHONE NUMBER		TYPE OF INJURY ILLNESS		PART OF BODY AFFECTED					
	DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE					
	ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED						
	SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED						
	HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.					CAUSE OF INJURY CODE				
	DATE RETURN TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO		WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
	PHYSICIAN HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)			INITIAL TREATMENT <input type="checkbox"/> 0 - NO MEDICAL TREATMENT <input type="checkbox"/> 1 - MINOR: BY EMPLOYER <input type="checkbox"/> 2 - MINOR CLINIC HOSPITAL <input type="checkbox"/> 3 - EMERGENCY CASE <input type="checkbox"/> 4 - HOSPITALIZED > 24 HOURS <input type="checkbox"/> 5 - FUTURE MAJ. MED. LOST TIME ANTICIPATED				
WITNESS (NAME & PHONE #)					DATE ADMINISTRATOR NOTIFIED			DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER
OTHERS										

NOTE > This form constitutes both the original notification of injury and detailed report of injury required by §287.380, RSMo (2000) and rules applicable thereto. An injury that requires immediate first aid, which does not result in further medical treatment or lost time from work, need not be reported to the Division. Employers should report all injuries to their workers' compensation insurance carrier or third-party administrator (TPA) within five days of the date of the injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. See §287.380, RSMo. If the employer has been granted self-insurance authority by the Division pursuant to §287.280, RSMo, and rules applicable thereto, please report all injuries to your TPA or Service Company to enable them to file this report with the Division.

PRINT QUALITY > All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division **MUST** be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE