



**North Dakota  
Workforce Safety  
& Insurance**  
*To us, it's personal.*

# FIRST REPORT OF INJURY

SFN 2828 (05/2007)

1600 EAST CENTURY AVENUE, SUITE 1  
PO BOX 5585  
BISMARCK ND 58506-5585  
**Telephone 1-800-777-5033**  
Toll Free Fax 1-888-786-8695  
TTY (hearing impaired) 1-800-366-6888  
Fraud and Safety Hotline 1-800-243-3331  
www.WorkforceSafety.com

**PLEASE PRINT OR TYPE USING BLACK OR BLUE INK AND RETURN TO WSI. Please see reverse side for Fraud Warning and other information.**

|  |  |               |  |  |  |  |  |
|--|--|---------------|--|--|--|--|--|
| <b>SECTION 1</b><br>Completion of this section is required | Claim Number   | Worker's Name | Social Security Number                                   | Injury Date  | Time of Injury<br><input type="checkbox"/> AM <input type="checkbox"/> PM  | Birth Date   |  |
|  | Worker's Mailing Address   |               |  |  |  | Sex<br><input type="checkbox"/> F <input type="checkbox"/> M | Marital Status<br><input type="checkbox"/> Single <input type="checkbox"/> Married |
|  | City   |               |  | State  | Zip  | Worker's Home/Cell Phone Number                              |  |
|  | Body Part Injured (Example: Left 2 <sup>nd</sup> /middle finger, right shoulder, left ankle.)  |               |  | What was the nature of the injury or illness? (Example: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.) |  |  |  |
|  | Tell us how the injury occurred and what the worker was doing before the incident (give details). (Example: "Worker was driving lift truck with pallet of boxes when the truck tipped, pinning driver's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry.") |               |  |  |  |  |  |
|  | Name of Treating Doctor(s)   |               | Clinic/Hospital  | E. R. Visit<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | Overnight Stay<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Date of First Treatment<br><input type="checkbox"/> N/A      |  |
|  | Address  |               |  | City   | State  | Zip  | Doctor's Phone Number  |
|  | Employer's Name  |               |  | What is the worker's occupation? (job title or duties)   |  |  |  |
|  | Employer's Address   |               | City   | State  | Zip  | Employer's Phone Number                                      |  |
|  | If job site, list location - (city, county, state, and zip)  |               | Employer's Premises<br>Job Site <input type="checkbox"/> | Time Worker Began Shift<br><input type="checkbox"/> AM <input type="checkbox"/> PM   | When did worker last work in<br>ND?  | Date Hired   |  |

|                                       |   |                        |   |  |              |
|---------------------------------------|---|------------------------|---|--|--------------|
| <b>SECTION 2</b><br>Worker Completion | Date employer notified and person you notified:   |                        | Have you had prior problems or injuries to that part of the body?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                 |  |              |
|                                       | Witness(es) to the Injury   | Address of Witness(es) | Have you missed five or more days from work or are you currently off work greater than five days?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |              |
|                                       | I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including records pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS related illness. I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer. |                        |   |  |              |
|                                       | Worker's Signature  |                        | Date Signed   | In addition to myself, I authorize WSI to release information on my claim to: (please print) |              |
|                                       |   |                        | First Name  | Last Name  | Relationship |

|   |  |        |  |                         |                                 |        |                                |
|---|--|--------|--|-------------------------|---------------------------------|--------|--------------------------------|
| <b>SECTION 3</b><br>Medical Provider Completion                                     | Type of Injury (fracture, bruise, cut, etc.)   |        |  | Date of First Treatment |                                 |        |                                |
|   | Has the incident caused the worker to miss five or more days work or is currently off work greater than five days?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |        | Diagnosis condition based upon objective medical findings:<br><b>Diagnosis code:</b> |                         |                                 |        |                                |
|   | Has the worker had any prior problems or injuries to that part of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details.           |        |  |                         |                                 |        |                                |
|   | Date worker may return to work: <input type="checkbox"/> Without work restrictions <input type="checkbox"/> With the following restrictions (list)                             |        |  |                         |                                 |        |                                |
|   | <b>Please complete the Physical Lifting Demand Level below - see guide on reverse side.</b>  |        |  |                         |                                 |        |                                |
|   | <input type="checkbox"/> Sedentary   | 10 lbs | <input type="checkbox"/> Light   | 20 lbs                  | <input type="checkbox"/> Medium | 50 lbs | <input type="checkbox"/> Heavy |
| Other instructions and/or limitations including prescribed medications or PT order: |  |        | Prognosis and anticipated length of medical treatment:                               |                         |                                 |        |                                |
| The above restrictions are in effect until:   |  |        | Re-evaluation date:  |                         | Time:                           |        |                                |
| Physician's Signature   |  |        | Date Signed  |                         | Physician's Federal Tax ID No.  |        |                                |

|   |  |                       |   |                               |   |  |  |
|---|--|-----------------------|---|-------------------------------|---|--|--|
| <b>SECTION 4</b><br>Employer Completion | Employer Account Number  | Worker's Rate Class   | Causation Code (See reverse)  | OSHA Log Number (See reverse) | Has the incident caused worker to miss five or more days from work or is currently off work greater than five days?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|   | Is worker a corp. officer, owner, partner, spouse or child under age 22? <input type="checkbox"/> Yes <input type="checkbox"/> No    |                       | Worker Status:<br><input type="checkbox"/> Full Time; <input type="checkbox"/> Part Time; <input type="checkbox"/> Seasonal; <input type="checkbox"/> Temporary |                               | First day worker lost wages due to work injury: <input type="checkbox"/> N/A  |  |  |
|   | Hourly Rate \$   | Hours Worked Per Week | Gross Earnings YTD \$<br>From to  |                               | Job description submitted or attached?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
|   | Has the worker had any prior problems or injuries to that part of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No |                       |   |                               |   | Date employer notified and person notified |  |
|   | Do you have a Designated Medical Provider (DMP)?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                         |                       | If yes, did the worker opt out? <input type="checkbox"/> Yes <input type="checkbox"/> No  |                               |   | Date of Death ( If applicable)             |  |
|   | If you question this claim, state reason (continue on back) or attach additional information.  |                       |   |                               |   |  |  |
| Employer's Signature                    |  |                       | Title   | Date Signed                   |   |  |  |



North Dakota State University

Authorization for Release of Information to Workforce Safety and Insurance

X Name of Employee: \_\_\_\_\_ X Date of Injury: \_\_\_\_\_

X DOB: \_\_\_\_\_ X SSN: \_\_\_\_\_

I authorize: \_\_\_\_\_ To release to: Workforce Safety and Insurance, PO Box 5585, Bismarck, ND 58506-5585, Phone: 701-328-3800, Toll Free Fax: 1-888-786-8695. Other: \_\_\_\_\_

Information To Be Disclosed

- Hospital Admission Summary, Hospital Discharge Summary, Operative Report, Psychiatric Intake, Psychiatric Interim, Verbal and/or written exchange about my medical information, Lab Reports, Progress Notes, Acknowledgment of my past and/or current admission as a patient in the facility, X-Ray Report, X-Ray Film, Entire Medical Record, X Prior Injury Medical Reports, X Pre-existing Condition Records

Other (please specify): \_\_\_\_\_

I authorize the release of all records pertaining to mental health, alcohol and/or drug abuse and/or HIV testing/Aids/Aids related illnesses.

Purpose

- Further Treatment, Insurance Application, Disability Determination, Vocational Rehabilitation Evaluation, Legal, Personal Records, Education, Payment of Insurance Claims, Workers Compensation Adjudication

Other \_\_\_\_\_

I understand I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. If not previously revoked, this authorization will expire in 12 months.

A photocopy or fax of this authorization will be treated in the same manner as the original.

X \_\_\_\_\_ X Date \_\_\_\_\_

Signature of Employee/Guardian/Representative

If not patient, state authority/relationship



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**INJURED WORKER CONTACT  
(PRIOR INJURY & PRE-EXISTING  
CONDITION FOLLOW-UP)  
CLAIMS DIVISION  
SFN 51153 (08/2007)**

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|                |              |               |
|----------------|--------------|---------------|
| Injured Worker | Claim Number | Body Part (s) |
|----------------|--------------|---------------|

1. Before your current injury, have you ever had any injuries or health problems, work related or not, to this area of your body?  Yes  No  
If no, skip to questions 12-17. If yes, please continue.

2. How long ago was the past injury or condition?

3. What was the diagnosis for your past injury or condition?

4. Please list any medical doctor, chiropractor, physical therapist, occupational therapist, or other health care professional that you treated with for your past injury or condition. (Continue on back if needed).

| Complete Name | Address | City, State, Zip | Phone | Time Frame |
|---------------|---------|------------------|-------|------------|
|               |         |                  |       |            |
|               |         |                  |       |            |
|               |         |                  |       |            |

5. When was the last time you were treated for your past injury or condition?

6. What type of treatment did you receive? (Medical doctor, chiropractor, physical therapist, etc.)

7. When was the last time you took medication for your past injury or condition?

8. What is the name of the medication(s) you took for your past injury or condition?

9. Does the past injury or condition continue to cause you pain and discomfort?  Yes  No  
If yes, please explain.

10. Explain the limits the past injury or condition has had on your daily activities?

11. Do you have any of the following as a result of your past injury or condition?  
 Loss of Motion  Limp  Prosthetic  Deformity  Scar  Orthotic

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|                |              |
|----------------|--------------|
| Injured Worker | Claim Number |
|----------------|--------------|

12. List all employers you have worked for in the last 10 years and what you did for each employer.

| Employer Name | Address | Telephone | Dates Employed |    |
|---------------|---------|-----------|----------------|----|
|               |         |           | From           | To |
|               |         |           |                |    |
| Duties:       |         |           |                |    |
|               |         |           |                |    |
| Duties:       |         |           |                |    |
|               |         |           |                |    |
| Duties:       |         |           |                |    |

13. Have you ever filed any other workers compensation or personal injury claims, in any state, for injuries or health problems?  Yes  No  
 If yes, in what state(s)? \_\_\_\_\_  
 Name of insurance company: \_\_\_\_\_ When? \_\_\_\_\_  
 Type of injury: \_\_\_\_\_

14. Have you ever received a permanent disability, impairment, or percentage rating in the past for any injury or health problems?  Yes  No  
 If yes, in what state(s)? \_\_\_\_\_  
 Name of insurance company: \_\_\_\_\_ When? \_\_\_\_\_  
 Type of injury: \_\_\_\_\_

15. Were you ever unable to work in the past due to injury or health problems?  Yes  No  
 If yes, for how long? \_\_\_\_\_

16. In the past, has any doctor or medical provider told you to avoid certain physical activities because of an injury or health problems?  Yes  No If yes, complete the following:

| Restriction | Doctor Who Initiated Restriction | Dates |    |
|-------------|----------------------------------|-------|----|
|             |                                  | From  | To |
|             |                                  |       |    |
|             |                                  |       |    |
|             |                                  |       |    |

17. Please list the names and addresses of all medical providers that you see for your routine medical care.

| Complete Name | Address | City, State, Zip | Phone | Time Frame |
|---------------|---------|------------------|-------|------------|
|               |         |                  |       |            |
|               |         |                  |       |            |
|               |         |                  |       |            |

**Fraud Warning for Filing False Claims**

Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for workers' compensation benefits will forfeit any future benefits and may be guilty of a felony which is punishable by imprisonment, substantial fines, or both. These criminal penalties are applicable to all persons dealing with the Fund, including injured workers, employers, medical providers, and attorneys.

To report an instance of fraud, contact the ND Fraud and Safety Hotline at 1-800-777-5033.

|                            |      |
|----------------------------|------|
| Injured Worker's Signature | Date |
|----------------------------|------|