

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP) Merchco Services, Inc. 140 Heimer Rd. #500 San Antonio, TX 78232				CARRIER/ADMINISTRATOR CLAIM NUMBER		OSHA LOG CASE #		REPORT PURPOSE CODE			
				JURISDICTION		JURISDICTION CLAIM NUMBER					
				INSURED REPORT NUMBER							
				EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #			
INDUSTRY CODE		EMPLOYER FEIN						PHONE #			
CARRIER/CLAIMS ADMINISTRATOR											
CARRIER (NAME, ADDRESS, & PHONE #)				POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)					
				TO							
				CHECK IF APPROPRIATE							
				☐ SELF INSURANCE							
CARRIER FEIN		POLICY/SELF-INSURED NUMBER				ADMINISTRATOR FEIN					
EMPLOYEE/WAGE											
NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE	
ADDRESS (INCL ZIP)				SEX		MARITAL STATUS		OCCUPATION/JOB TITLE			
				☐ M MALE ☐ F FEMALE ☐ U UNKNOWN		☐ U UNMARRIED SINGLE/DIVORCED ☐ M MARRIED ☐ S SEPARATED ☐ K UNKNOWN		EMPLOYMENT STATUS			
				# OF DEPENDENTS				NCCI CLASS CODE			
PHONE											
RATE PER:		DAY WEEK		MONTH OTHER:		DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		YES YES NO NO	
OCCURRENCE/TREATMENT											
TIME EMPLOYEE BEGAN WORK		AM PM		DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		AM PM		LAST WORK DATE	
						() CANNOT BE DETERMINED				DATE EMPLOYER NOTIFIED	
CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED			
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?				TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE			
☐ YES ☐ NO											
DEPARTMENT OR LOCATION WHERE 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(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?				YES YES NO NO			
				WERE THEY USED?				YES YES NO NO			
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)				INITIAL TREATMENT			
								0 NO MEDICAL TREATMENT			
								1 MINOR: BY EMPLOYER			
								2 MINOR CLINIC/HOSP			
								3 EMERGENCY CARE			
								4 HOSPITALIZED > 24 HOURS			
				5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED							
OTHER											
WITNESSES (NAME & PHONE #)											
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER			