

# DAS

## First Report of Injury WC 207

**Reference No:**

Central Office use only:  
Incident No:

Claim No:

**The Supervisor must complete this form with the injured worker and then forward it along with the balance of the claim package to the Workers' Compensation Unit within 24 hours.**

1. AgencyLocationCode		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		11. Date of Hire	12.Date of Incident	13.Time of Incident
14.Time Employer Notified	15.Date Employer Notified	16. Was Injury Fatal? YES NO		17. Date of Fatality
18. How Did the Injury Occur?				
19. Type of Injury		20. Body Part(s) Affected		21. Category of Illness or Injury
22. Did Injury Occur on Employer Premises? <input type="checkbox"/> YES <input type="checkbox"/> NO		23. Location Injury Occured		
24. Injured Worker Seeking Medical Treatment <input type="checkbox"/> YES <input type="checkbox"/> NO If yes complete question 25		25. Medical Care Provided By: (Physician Name and Address)		
26. Were There Any Witnesses to the Injury? (If yes, give name, address and phone.)				
27. To Whom Was Injury Reported?		(Name)	(Title)	
<b>28. SUPERVISOR CONTACT INFO</b> Please print		Name: Work Phone: Best Time to Contact:		
I HAVE REVIEWED THE ABOVE FORM FOR COMPLETENESS				
29. Signature of Supervisor (or other Designated Authority)				
SUPERVISORS REPORT ALL INJURIES - CALL 1-800-828-2717 white agency copy    yellow agency copy    pink employee copy				