THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2
Rev. 10/2012

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE

1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name 5. Physical Address 1 6. Physical Address 2 7. City 8. State 9. Zip	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS 10. Mailing Address 1 11. Mailing Address 2 12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number	17. NAICS

INSURER / FILING OFFICE

18. Insurer Name ASSOCIATION OF COUNTY COMMISSIONS OF AL SI FUND 19. Insurer Federal ID Number 63-0821025 20. Type Insurer Ins Co ☐ Self-Insurer ☐ Group Fund ☐	21. Filing Office Name COUNTY RISK SERVICES, INC. 22. Mailing Address 1 P.O. Box 589 23. Mailing Address 2 or Telephone Number (334) 394-3232 24. City Montgomery 25. State AL 26. Zip 36101-0589 27. Filing Office Federal ID Number 83-0814426

EMPLOYEE / WAGES

28. First Name 29. Middle Name 30. Last Name 31 Last Name Suffix (ie. Jr., Sr., III)	32. Employee ID Number 33. Type Employee ID Number SSN ☐ Passport Number ☐ Green Card ☐ Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1 35. Mailing Address 2 36. City 37. State 38. Zip 39. Phone	40. Gender Male ☐ Female ☐	41. Date of Birth 42.Nbr of Dependents

43. Marital Status Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐	44. Date Hired
45. Occupation Description	46. Number of Days Worked Per Week

47. Wages $ 48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐	49. Received Full Pay For Day of Injury? Yes ☐ No ☐ 50. Did Salary Continue? Yes ☐ No ☐

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE 56. Site Address 57. City 58. State 59. Zip 60. County	61. Injury Occurred on Employer's Premises? Yes ☐ No ☐ 62. Date Employer Notified

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

67. Initial Treatment First Aid By Employer ☐ Emergency Room ☐ Hospitalized > 24 Hours ☐	No Medical Treatment ☐ Minor Clinic / Hospital ☐ Hospitalized Overnight ☐ Outpatient Treatment ☐	68. Name of Treatment Facility 69. Address 70. City 71. State 72. Zip

73. Name of Physician or Other Health Care Professional	74. Has Injured Returned to Work Yes ☐ No ☐	If so, 75. Date 76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name	79. Last Name	80. Title	81. Preparer's Telephone Number