IDF - Injury, Illness, Incident Data Form (replaces First Report of Injury or FRI)

Instructions: This form is for the collection and reporting of data associated with a work-related, injury, illness or incident. Supervisors must complete this entire form and submit either by email (preferred method) or signed paper copy to the Agency Workers' Compensation Coordinator within 24 hours of receiving notice of the injury, illness or incident. **Do not email directly from web site. Save completed form to your computer, then email.** Supervisors should immediately contact CorVel (the state's workers' compensation managed health care system) at 612-436-2542 or 1-866-399-8541, if an injured employee is admitted to an overnight stay at a hospital or requires immediate surgery on day of injury.
Please contact your agency/facility's Workers' Compensation Coordinator with any questions.
Checklists, forms, and more information are available at: http://mn.gov/admin/government/risk/workers-comp/procedures/

Report Preparer

1. Reporter Employee ID #:	2. First Name:	3. Last Name:	4. Reporter Phone:
5. Are you reporting for one of the following: ☐Yes ☐No	☐ Conservation Corp MN ☐ Historical Society	☐ House of Representatives ☐ Minnesota State Fair	☐ State Senate
6. Agency/organization reporting for	7. Agency/organization subdivision	8. Are you the Injured employee's supervisor: ☐Yes ☐No	

Employee's Supervisor

9. Supervisor First Name:	10. Supervisor Last Name:
11. Supervisor Phone Number:	12 Supervisor Email Address:

Injured Employee

13. Incident Date (mm/dd/yyyy)	14. Employee ID Number:	15a. Last Name	15b. First Name

Incident Information

16. Employee seek medical care from provider ☐Yes ☐No	17. Employee miss time from work due to incident: ☐Yes ☐No	18. Time of Incident (hh:mm)
19. Time Employee Began Work (hh:mm)	20. Incident result in fatality: ☐Yes ☐No	21.Date Employer Notified of Incident (mm/dd/yyyy):
22.Incident occurred on Employer's premises: ☐Yes ☐No	23.Location of Incident:	

24.How did the injury or illness occur and what the employee was doing before the incident:

25. What was the injury or illness (include the parts of the body):

26. What substances, object, equipment, tools or machines were involved:

27 First Date Of Lost Time:	27 Date Employer Notified of Lost	28. Emergency Room Visit: ☐Yes ☐No	29. Overnight In-Patient Stay: ☐Yes ☐No

30. Treating Physician	31. Physician Phone:	32. Address

33. City	34. State	35. Zip Code:	36. Hospital/Clinic (name)

37. Hospital/Clinic (Address)	38. City .	39. State	40. . Zip Code:

41.Does employee receive income from and employer other that the State of Minnesota: ☐Yes ☐No	42. Weekly value of 2nd income if known:

Witness

43. Were there any witness to the incident/injury: ☐Yes ☐No	44.Witness First Name:	45: Witness Last Name	46. Witness Phone Number:

iRISK – Injury/Illness Description

47. Body Part:	48. Nature Of Injury:	49. Claim Cause:	50. source of Injury:

51. Initial Treatment		
	☐ Emergency evaluation. Diag testing and medical procedures	☐ Future Major Med/Lost Time Anticipated
	☐ Hospitalization > 24 hours	☐ Minor clinic/hospital med remedies and diagnostic testing
	☐ Minor on-site remedies by employer medical staff	☐ No medical treatment

Insurer: Minnesota Dept. of Administration Risk Management Division, Workers Compensation Program 310 Centennial Office Bldg. 658 Cedar Street, St. Paul, MN 55155 Phone (651) 201-3000	For Agency Use:	WC Claim# _____ WC Claims Specialist _____ Agency hire date: _____ Type: _____
		Rev 8/2015