

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: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Conservation Corp MN <input type="checkbox"/> Historical Society	<input type="checkbox"/> House of Representatives <input type="checkbox"/> Minnesota State Fair	<input type="checkbox"/> State Senate
6. Agency/organization reporting for	7. Agency/organization subdivision	8. Are you the Injured employee's supervisor: <input type="checkbox"/> Yes <input type="checkbox"/> 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
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Incident Information

16. Employee seek medical care from provider <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Employee miss time from work due to incident: <input type="checkbox"/> Yes <input type="checkbox"/> No	18. Time of Incident (hh:mm)
19. Time Employee Began Work (hh:mm)	20. Incident result in fatality: <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Date Employer Notified of Incident (mm/dd/yyyy):
22. Incident occurred on Employer's premises: <input type="checkbox"/> Yes <input type="checkbox"/> 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 Time 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 than 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 For Agency Use: WC Claim# _____ WC Claims Specialist _____

Risk Management Division, Workers Compensation Program Agency hire date: _____ Type: _____

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