



**State of Connecticut  
Workers' Compensation Commission**

*Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011*

Rev. 7-13-2009

# FRI

Date filed in Chairman's Office

## Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

(for WCC use only)

Employer (Name, Address & Zip)		Phone #	Carrier / Administrator Claim #		OSHA Log Case #	Report Purpose Code
SIC Code		FEIN		Jurisdiction	Jurisdiction Claim #	
				Employer's Location Address (if different)		Phone #
Carrier (Name, Address & Zip)		Phone #	Claims Administrator (Name, Address & Zip)		Phone #	
Policy / Self-Insured #			<input type="checkbox"/> Check, if Self-Insured	Policy Period (MM/DD/YY)		
				FROM:	TO:	
Employee: Last Name		First Name	Middle Name	Gender	Date Hired (MM/DD/YY)	State of Hire
D.O.B. (required)		Phone #		<input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation / Job Title	
Address (incl. Zip)					Rate of Pay \$ _____ per	NCCI Class Code
				<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other		
Date of Injury / Illness (MM/DD/YY)		Town of Injury / Illness		Physician / Health Care Provider (Name, Address & Zip)		
Time Employee Began Work		<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Did Injury / Illness occur on Employer's Premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital (Name, Address & Zip)	
Time of Occurrence		<input type="checkbox"/> cannot be determined <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Type of Injury / Illness			
Date Employer Notified (MM/DD/YY)		Part of Body Affected				
Date Disability Began (MM/DD/YY)		Type of Injury / Illness Code				
Date Last Worked (MM/DD/YY)		Part of Body Affected Code		Initial Treatment		
Date Return(ed) to Work (MM/DD/YY)		Were Safeguards or Safety Equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Fatal, Date of Death (MM/DD/YY)		If provided, were they used? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Care		
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:		How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:		<input type="checkbox"/> Minor — by Employer <input type="checkbox"/> Hospitalized More Than 24 Hours		
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:				<input type="checkbox"/> Minor — by Clinic / Hospital <input type="checkbox"/> Future Major Medical — Lost Time Anticipated		
Contact Name				Date Administrator Notified (MM/DD/YY)	Date Prepared (MM/DD/YY)	
Phone #		Cause of Injury Code		Preparer's Name & Title		Phone #

STATE OF CONNECTICUT  
WORKERS' COMPENSATION COMMISSION

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS  
BY A HOSPITAL/PROVIDER  
FOR THE PURPOSE OF ADMINISTERING A  
CONNECTICUT WORKERS' COMPENSATION CLAIM FOR BENEFITS**

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PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
(PLEASE PRINT NAME) (REQUIRED)

BODY PART(S): \_\_\_\_\_

I, the undersigned, authorize: \_\_\_\_\_  
(HOSPITAL/PROVIDER)

to disclose, in writing, protected health information [PHI] to:

\_\_\_\_\_  
(PERSON OR ENTITY TO WHOM INFORMATION IS TO BE DISCLOSED)

and its attorneys and/or representatives. The PHI to be disclosed is relevant medical records and reports relating to my medical treatment/consultation/examination and/or diagnostic procedures performed at the above-named medical facility and which pertain to an injury/occupational disease for which I am claiming benefits under the Connecticut Workers' Compensation Act. I understand the information disclosed based on this authorization may include mental health treatment records and information regarding HIV/AIDS status, treatment or testing. **INFORMATION RELATING TO TREATMENT FOR ALCOHOL AND DRUG ABUSE WILL NOT BE RELEASED WITHOUT MY SPECIFIC CONSENT in accordance with state and federal law.**<sup>1</sup> I understand I have the right to inspect or copy the PHI to be disclosed as permitted under federal HIPAA law and state law.

**I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.**

**I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION.** In order to revoke this authorization I may, at any time, send written notification to the above-named HOSPITAL/PROVIDER. I understand that my revocation of this authorization is ineffective to the extent that the above-named HOSPITAL/PROVIDER has relied on this authorization to disclose PHI relating to me.

**I UNDERSTAND THAT PHI DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE PERSON OR ENTITY I HAVE IDENTIFIED ABOVE AND MAY NO LONGER BE PROTECTED FROM DISCLOSURE TO OTHERS BY FEDERAL OR STATE LAW.** I understand that the above-named HOSPITAL/PROVIDER may not condition my treatment on whether I provide authorization for the requested use or disclosure.

**I UNDERSTAND THAT I HAVE THE RIGHT TO DETERMINE A DATE OR EVENT AT WHICH TIME THIS AUTHORIZATION EXPIRES.** I am identifying the expiration date of this authorization to be COMPLETION OF WORKERS' COMPENSATION LITIGATION AS EVIDENCED BY A STIPULATION OR FINDING AND AWARD/DISMISSAL, OR IN THE EVENT OF APPELLATE REVIEW, A FINAL DETERMINATION BY THE HIGHEST APPELLATE AUTHORITY TO WHOM AN APPEAL IS MADE.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this authorization relates to a Workers' Compensation matter. However, I understand that as a practical matter, my authorization in this form may facilitate the processing and administration of my claim for Workers' Compensation benefits.

**My signature below indicates that I have read and understand this Authorization and its terms.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

<sup>1</sup> Any consent to release information pertaining to treatment for drug and alcohol abuse must conform to the requirements of state law and the federal regulations, e.g., Part 2 of Title 42 of the Code of Federal Regulations.