

Policy Number _____

EMPLOYER'S FIRST REPORT

OF OCCUPATIONAL INJURY OR DISEASE

Policyholder:
General Conference of
Seventh-day Adventists
12501 Old Columbia Pike
Silver Spring, MD 20904-6600

Employer _____

Address _____

Telephone ____ (____) _____

Nature of Business _____

Division _____

EMPLOYEE	EMPLOYEE: First _____ Middle _____ Last _____		Marital Status _____		Employee Social Security No. _____	
	Address (include country and zip code) _____					
	Date of Birth _____		Volunteer Worker <input type="checkbox"/>	Regular Worker <input type="checkbox"/>		
	Country of Origin _____	Occupation _____			How Long Employed _____	
	Spouse (If injured or sick) _____		Date of Birth _____		Social Security No. _____	
DATES	Date of injury and time _____		Normal Starting Time _____		If Employee Back To Work Give Date _____	
	If Fatal Injury, Give Date of Death _____		Date Employer Know of Injury _____		Date Disability Began _____	
INJURY OR DISEASE	Describe the Injury/Illness and Part of the Body Affected _____			Medical Evacuation/Repatriation To: _____		
	Specify the Department Where Incident Occurred and the Work Process Involved _____					
OCCURRENCE	List the Equipment, Materials, and Chemicals Employee Was Using When the Incident Occurred, e.g. Acetylene _____					
	Describe the Employee's Activity at the Time of Injury or Illness. _____					
	Describe How the Injury/Illness Occurred _____					
	Name of Physician _____		Physician's Address _____			
	Hospital (If applicable) _____		Hospital Address _____			
WAGE INFO	Rate PER: _____ Hour _____ Day _____ Week _____ Month _____ Other _____					
	Full Pay for Day of Injury <input type="checkbox"/> YES <input type="checkbox"/> NO		Did Salary Continue <input type="checkbox"/> YES <input type="checkbox"/> NO			
	Average Wage/Week at Time of Injury – Complete WEEKLY EARNINGS SCHEDULE (Overleaf)					
Date of the Report: _____		Signed by: _____		Official Title: _____		

For all accidental medical, endemic/occupational sickness claims, provide: Medical Report; Itemized Medical Bills; Weekly Earnings Schedule; and Police Report (if accident).

For medical evacuation/repatriation submit: Doctor's recommendation, airline tickets.

For death submit: Death Certificate, police report, medical report, funeral expenses, repatriation expenses, airline tickets, marriage and birth certificates (spouse & children), Weekly Earnings Schedule.

WEEKLY EARNINGS SCHEDULE
26 Weeks

W26

Please complete and return the Weekly Earnings Schedule below, which is required by Compensation Law, even though there may have been no loss of time from work.

Your cooperation in promptly completing and returning this form in the enclosed addressed envelope will be appreciated.

DATE		EMPLOYEE				FILE NO			
DATE OF ACCIDENT		DATE DISABILITY BEGAN		DATE COMPENSATION BEGIN		DATE EMPLOYED			
<i>Include Gross Earnings As Amount Paid. Do not include record of earnings for the week during which the accident occurred. If injured was not paid on weekly basis, explain fully, and give earnings during 26 weeks preceding accident</i>									
Week NO.	WEEK		AMOUNT PAID EXCLUDING OVERTIME	PAID FOR OVERTIME OR EXTRA WORK	WEEK NO.	WEEK		AMOUNT PAID EXCLUDING OVERTIME	PAID FOR OVERTIME OR EXTRA WORK
	From (Date)	To (Date)				From (Date)	To (Date)		
	XXX	XXX	XXX	XXX	<i>Totals carried forward</i>				
1					14				
2					15				
3					16				
4					17				
5					18				
6					19				
7					20				
8					21				
9					22				
10					23				
11					24				
12					25				
13					26				
<i>Carry totals forward</i>								TOTALS	
<i>Remarks</i>									

I certify that the above is a true copy of payroll record of INJURED'S earnings as shown on Employer's records.

Signed _____

Title _____