WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME AND ADDRESS INCL. ZIP)
City of Gulfport
Post Office Box 1780
Gulfport, MS 39502

CARRIER/ADMINISTRATOR CLAIM NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #:

PHONE #228-868-5831

SIC CODE | EMPLOYER FEIN
64-6000413

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO.)
City of Gulfport
Post Office Box 1780
Gulfport, MS 39502
(228) 868-5811

POLICY PERIOD
TO

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)
Associated Adjusters, Inc.
Post Office Box 357
Gulfport, MS 39502
(228) 865-9181

CARRIER FEIN
64-6000413

POLICY/SELF INSURED NUMBER

ADMINISTRATOR FEIN
64-0655545

AGENT NAME AND CODE NUMBER
Stewart, Sneed, & Hewes, Inc.

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL. ZIP)

SEX
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS
☐ UNMARRIED/SINGLE/DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

NCCI CLASS CODE

RATE
$ PER Hour

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? YES ☐ NO ☐
DID SALARY CONTINUE? YES ☐ NO ☐

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK | ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ☐ **AM** ☐ **PM** | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER
Saunya Lamb 228-868-5831

TYPE OF INJURY OR ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS OCCUR ON EMPLOYER PREMISES?
YES ☐ NO ☐

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO
WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS)

HOSPITAL (NAME AND ADDRESS)

INITIAL TREATMENT
☐ NO MEDICAL TREATMENT
☐ MINOR: BY EMPLOYER
☐ MINOR CLINIC/HOSPITAL
☐ EMERGENCY CARE
☐ HOSPITALIZED > 24 HOURS
☐ FUTURE MAJOR MEDICAL /LOST TIME ANTICIPATED

WITNESSES (NAME AND PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

		Saunya Lamb, Benefits Administrator	228.868.5831

CITY OF GULFPORT – EMPLOYEE ACCIDENT OR INJURY REPORT

Employee Information (Please Print Clearly)

Emp. ID # ___ Employee Name: _____ Date of Hire: _____

Occupation/Job Title: _____ Date of Birth: _____ SSN# _____

Sex: ___ Marital Status: ___ Home Phone # _____ Work Phone # _____

Address: _____

Accident/Treatment Information:

Date of Accident: _____ Time of Accident: _____ Time Work Begin: _____

Where did accident occur? _____

Date Employer Notified: _____ Who was notified? _____

Were you injured in the accident? ☐YES ☐NO Type of Injury: _____

Specific body part (s) involved: _____

Specific activity involved in at time of injury/illness: _____

_____

Work process involved in at the time of injury/illness: _____

_____

Describe in detail how the accident/injury occurred: _____

_____

_____

Were you using any equipment, materials or chemicals at the time of the accident? ☐YES ☐NO

If yes, what equipment, materials or chemicals were you using? _____

Were safeguards or safety equipment provided? ☐YES ☐NO

If yes, what safeguards or safety equipment were you using? _____

Did you seek medical attention: ☐YES ☐NO If yes, did you have any work restrictions? ☐YES ☐NO

If yes, where did you seek medical attention? _____

Date returned to work? _____

Who witnessed this accident? (Name and phone#) _____

Employee's Signature: _____ Date: _____

NOTE: Please forward within 24 hours of accident to: Human Resources, ATTN; Benefits Administrator

Notice
To
Mississippi Workers' Compensation Commission

Physician of Choice Form

Employee Name: _____

Employer Name: _____

Injury Date: _____

I understand that under the Mississippi Workers' Compensation law I have the right to choose one physician to render treatment to me. I can either accept the physician to whom I am sent by my employer or choose someone else on my own.

I also understand that any referral to any other doctor **must** be made by my one chosen physician.

I also understand that my employer (or workers' compensation carrier/administrator) must approve any physician change, and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

☐ I accept as my choice of physician my employer's tender of treatment by:

Medical Analysis, 3310 17th Street, Gulfport, MS 39501~ 228-863-6760

☐ I elect to choose my own physician to render treatment, and that choice is:

_____

_____ _____

Employee's Signature Date