# South Dakota Employer's First Report of Injury

(See Instructions on Second Page)

**EMPLOYEE**

SSN: Date of Birth: Gender: M F Dependents:

Name: (Last) (First) ( Middle initial)

Mailing Address:

City: State: Zip: Telephone No.:

Employee signature: (X) ____________________ Date__________

Education:

- Less than High School
- GED or High School
- Beyond High School

**INJURY/TREATMENT**

Date of Injury: Time of Injury: a.m. p.m. Fatality Date (if applicable):

County Where Injury Occurred: Was Safety Equipment Provided? Yes or No

Time Work Day Began on Date of Injury: a.m. p.m. Was Safety Equipment Used? Yes or No

Date Returned to Work (if applicable): Did Injury Occur on Employer Premises? Yes or No

Address or Location of Injury:

Description of Injury:

Date Employer Notified of Injury:

Injury Reported to: Witness:

(See Codes on Second Page)

Body Part Injured

(If code 90, Multiple Injury, please specify body part codes for each body part injured.)

Nature of Injury

Cause of Injury

Type of Treatment (please check one)

- No Treatment
- On-Site Treatment
- Clinic
- Emergency Room
- Hospitalization

If treatment sought, please specify provider of treatment:

Doctor, Clinic or Hospital Name:

Mailing Address:

City: State Zip

Telephone No. :

**EMPLOYER/EMPLOYMENT INFORMATION:**

Federal ID No.: # Employees:

Employer Name (DBA):

Mailing Address:

City: State: Zip:

Telephone No. : County Where Employer Located:

Employer signature: ____________________ Date__________

Employment Type: Regular or Temporary

Emp. Status: FT PT Seasonal Volunteer

Date Employee Hired:

Employee's Position:

Employee's Time in Current Position:

Employee's Hours Per Week:

Employee's Current Wage:

$ per

## CLAIM OFFICE INFORMATION

NAICS for Employer Being Insured (Nature of Business):

Carrier Code FEIN (Claim Office)

Claim Office

Claim Office Address

City State ZipCode

Telephone

Email Address T

Claim Office Claim #

Date Notified Date to DOL

Check if Claim Office is same as Insurance Provider

If not, you must complete the following
UNDERLYING INSURANCE PROVIDER INFORMATION

Carrier Code (If applicable) FEIN (Insurance Provider)

Represented Entity Name

Address

City State Zip Code

elephone Number

Policy Number

Effective Dates

Adjuster / Contact Person

For information regarding the Workers' Compensation System please visit www.sdjobs.org

## GENERAL INSTRUCTIONS

**EMPLOYEE**

1.Á Notify employer immediately of injury, as required by SDCL 62-7-10.
2.Á Complete all questions in the EMPLOYEE and INJURY/TREATMENT sections.
3.Á Sign the form.
4.Á Submit this form to your employer within three (3) business days after the injury.

**EMPLOYER**

1.Á Complete all questions in the EMPLOYER/EMPLOYMENT sections.
2.Á Sign the form.
3.Á Submit this form to your workers' compensation insurance carrier within seven (7) days of knowledge of the occurrence of the injury, as required by SDCL 62-6-2.
4.Á Give a copy of the form to the injured employee.
5.Á Keep the copy of the First Report of Injury for at least four (4) years from the date of injury, as required by SDCL 62-6-1.

**BODY PART CODES**

| Code | Body Part | Code | Body Part | Code | Body Part |
|---|---|---|---|---|---|
| 02 | Blindness one eye | 44 | Chest, including ribs sternum, soft ribs | 78 | Ring finger at metacarpal bone |
| 03 | Blindness both eyes | 48 | Internal organs-other than heart, lungs | 79 | Ring finger at proximal joint |
| 04 | Deafness both ears | 49 | Heart | 80 | Ring finger at middle joint |
| 05 | Deafness one ear | 51 | Hip | 81 | Ring finger at distal joint |
| 10 | Multiple head injury | 52 | Upper leg | 82 | Little finger at metacarpal bone |
| 11 | Skull | 53 | Knee | 83 | Little finger at proximal joint |
| 12 | Brain | 54 | Lower leg | 84 | Little finger at middle joint |
| 13 | Ear(s) | 55 | Ankle | 85 | Little finger at distal joint |
| 14 | Eye(s) | 56 | Foot | 86 | Great toe metatarsal bone |
| 17 | Mouth | 57 | Toe (other than greater) | 87 | Great toe at proximal joint |
| 19 | Face (facial bones) | 58 | Toe (greater) | 88 | Great toe at distal joint |
| 20 | Multiple neck injury | 60 | Lungs | 90 | Multiple injury |
| 21 | Vertebrae | 61 | Groin | 92 | Other toe metatarsal bone |
| 22 | Disc | 67 | Thumb metacarpal bone | 93 | Other toe at proximal joint |
| 24 | Other | 68 | Thumb at proximal joint | 94 | Other toe at middle joint |
| 31 | Upper arm | 69 | Thumb at distal joint | 95 | Other toe at distal joint |
| 32 | Elbow | 70 | Index finger at metacarpal bone | 96 | Little toe metatarsal bone |
| 33 | Lower Arm-forearm | 71 | Index finger at proximal joint | 97 | Little toe at distal joint |
| 34 | Wrist | 72 | Index finger at middle joint | | |
| 35 | Hand | 73 | Index finger at distal joint | | |
| 37 | Thumb | 74 | Middle finger at metacarpal bone | | |
| 38 | Shoulder | 75 | Middle finger at proximal joint | | |
| 41 | Upper Back | 76 | Middle finger at middle joint | | |
| 42 | Lower Back | 77 | Middle finger at distal joint | | |

**Cause of Injury Codes**

| Code | Cause | Code | Cause |
|---|---|---|---|
| 01 | Body reaction/over reaction (includes chemicals) | 70 | Striking against or stepping on |
| 03 | Temperature extremes | 78 | Struck or injured by moving parts of machine |
| 13 | Caught in/under/between | 81 | Struck or injured, includes knife or sharp object, kicked, bit, etc. – struck by object, worker, patient, etc. |
| 25 | Fall from elevation | 89 | Hostile attack-person in act of crime |
| 29 | Fall from same level | 90 | Other than physical cause of injury |
| 50 | Motor vehicle | 94 | Repetitive motion – callous, blister, etc. |
| 56 | Bending/Lifting | 97 | Repetitive motion-carpal tunnel syndrome, etc. |
| 65 | Machinery/Equipment | 99 | Other |

**Nature of injury codes**

| Code | Nature |
|---|---|
| 00 | Not applicable |
| 01 | Allergy |
| 02 | Disfigurement |
| 71 | Occupational disease |
| 72 | Hearing loss |

dlr south dakota department of labor and regulation

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