MN Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

First Report of Injury

See Instructions on Reverse Side

PRINT IN INK or TYPE
ENTER DATES IN MM/DD/YYYY FORMAT

Reset

FR01

DO NOT USE THIS SPACE

1. **EMPLOYEE SOCIAL SECURITY #**	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm

4. **DATE OF CLAIMED INJURY**	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)

7. **EMPLOYEE** Name (last, suffix, first, middle)	8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried

10. Home address	11. Home phone #	12. Date of birth	13. Date hired
City State Zip Code	14. Occupation	15. Regular department	16. Apprentice ☐ Yes ☐ No

17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week	Normal work schedule Sun - Sat (S M T W T F S) ☐ ☐ ☐ ☐ ☐ ☐ ☐	21. Employment status (check all that apply) ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No Name and address of the place of the occurrence	26. First date of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI
	28. Date employer notified of injury	29. Date employer notified of lost time
	30. Return to work date	31. RTW same employer ☐ Yes ☐ No 32. RTW with restrictions ☐ Yes ☐ No

33. Treating physician (name)	34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated
35. Certified Managed Care Organization (if any)	

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)
PARAKLATOS INC. DBA	PKT ENTERPRISES
38. **Mailing** address	39. Employer FEIN / 40. Unemployment ID #
724 NORTH 1ST STREET, SUITE 600	411790674
City State Zip Code	41. Employer's contact name and phone #
MINNEAPOLIS MN 55401	PAT MATT 612/788-3998 EXT. 104
42. **Physical** address (if different)	43. Witness (name and phone) - if more than 1 attach a separate sheet
City State Zip Code	44. NAICS code / 45. Date form completed

46. **INSURER** name	51. **CLAIMS ADMIN COMPANY (CA)** name (check one) ☑ Insurer ☐ TPA
SFM MUTUAL INSURANCE	SFM MUTUAL INSURANCE COMPANY
47. Insured legal name and FEIN	52. CA address
PARAKLATOS INC. 411790674	CLAIMS SERVICES, PO BOX 9416
48. Policy # (including effective dates) or self-insured certificate #	City State Zip Code
SF.358692.210	MINNEAPOLIS MN 55440
49. Insurer FEIN / 50. Date insurer received notice	53. CA FEIN / 54. CA claim #
411459789	411459789

55. To be completed by the **CA**:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?