# NOTICE:
## ALABAMA WORKERS COMPENSATION

**This business operates under Alabama Workers Compensation Law.**

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, OR AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR OR FOREMAN OF THE EMPLOYER.

**Workers Compensation insurance benefits are provided through:**

BerkleyNet

**To report a claim, contact us at:**

Website: berkleynet.com
Email: claims@berkleynet.com
Address: 9301 Innovation Drive, Suite 200, Manassas, VA 20110
Phone: 877.497.2637
Fax: 866.275.6320

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKERS'S COMPENSATION LAW

WCC Form 2
Rev. 9/2006

# STATE OF ALABAMA
## EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE
**Ombudsman 1-800-528-5166**

### CLAIM REFERENCE

| 1. Insured Report Number | 2. Filing Office Claim Number | 3. OSHA Log Case Number |
|---|---|---|
| | | |

### EMPLOYER

| | |
|---|---|
| 4. Employer Business Name<br>5. Physical Address 1<br>6. Physical Address 2<br>7. City 8. State 9. Zip | ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS<br>10. Mailing Address 1<br>11. Mailing Address 2 or Telephone Number<br>12. City 13. State 14. Zip |

| 15. Federal ID Number | 16. U.C. Account Number | 17. NAICS |
|---|---|---|
| | | |

### INSURER / FILING OFFICE

| | |
|---|---|
| 18. Insurer Name<br>19. Insurer Federal ID Number<br>20. Type Insurer ☐ Insurance Co. Ins Co #<br>☐ Self-Insurer SI #<br>☐ Group Fund GF # | 21. Filing Office Name 21a. Service Co. #<br>22. Mailing Address 1<br>23. Mailing Address 2 or Telephone Number<br>24. City 25. State 26. Zip<br>27. Filing Office Federal ID Number |

### EMPLOYEE / WAGES

| | |
|---|---|
| 28. First Name<br>29. Middle Name<br>30. Last Name<br>31 Last Name Suffix (ie. Jr., Sr., III) | 32. Employee ID Number<br>33. Type Employee ID Number<br>SSN ☐ Passport Number ☐ Green Card ☐<br>Employment Visa ☐ Assigned by Jurisdiction ☐ |

| | | |
|---|---|---|
| 34. Mailing Address 1<br>35. Mailing Address 2<br>36. City 37. State 38. Zip 39. Phone | 40. Gender<br>Male ☐<br>Female ☐ | 41. Date of Birth<br>42.Nbr of Dependents |

| | |
|---|---|
| 43. Marital Status<br>Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐ | 44. Date Hired |
| 45. Occupation Description | 46. Number of Days Worked Per Week |
| 47. Wages $<br>48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ | 49. Received Full Pay For Day of Injury? Yes ☐ No ☐<br>50. Did Salary Continue? Yes ☐ No ☐ |

### INJURY / TREATMENT

| 51. Date of Injury | 52. Time of Injury<br>a.m. ☐ p.m. ☐ unk ☐ | 53. Time Employee Began Work<br>a.m. ☐ p.m. ☐ | 54. Date Disability Began | 55. Date of Death |
|---|---|---|---|---|
| | | | | |

| | |
|---|---|
| PLACE OF ACCIDENT, INJURY, OR EXPOSURE<br>56. Site Address<br>57. City 58. State 59. Zip 60. County | 61. Injury Occurred on Employer's Premises?<br>Yes ☐ No ☐<br>62. Date Employer Notified |

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. ( Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

**PROVIDE DESCRIPTION CODES** to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
**(FOR COMPLETE LIST OF CODES, GO TO HTTP:// DIR.ALABAMA.GOV/WC**

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

| | |
|---|---|
| 67. Initial Treatment<br>No Medical Treatment ☐ First Aid By Employer ☐<br>Minor Clinic / Hospital ☐ Emergency Room ☐<br>Hospitalized > 24 Hours ☐ Major medical/Lost time ☐<br>Hospitalized Overnight ☐ | 68. Name of Treatment Facility<br>69. Address<br>70. City 71. State 72. Zip |

| 73. Name of Physician or Other Health Care Professional | 74. Has Injured Returned to Work<br>Yes ☐ No ☐ | If so, 75. Date<br>76. Time a.m. ☐ p.m. ☐ |
|---|---|---|
| | | |

### OTHER

| 77. Date Prepared | 78. Preparer's First Name 79. Last Name 80. Title | 81. Preparer's Telephone Number |
|---|---|---|
| | | |

# STATE OF ALABAMA
# WORKERS' COMPENSATION INFORMATION

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE CARRIER_____

TELEPHONE NUMBER_____

**ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS' COMPENSATION LAW INCLUDING MEDIATION SERVICE.**
**FOR INFORMATION CALL:**
**1-800-528-5166**
**Alabama Department of Labor**
**Workers' Compensation Division**
**649 Monroe Street**
**Montgomery, AL 36131**

**CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.**

FORM WCC#1 10/12