ACCIDENT INFORMATION

EMPLOYEE'S REPORT OF INJURY

ATTENTION EMPLOYEE: SDCL 62-4-51 provides that any person who knowingly files a fraudulent claim for worker's compensation benefits is guilty of a Class 1 misdemeanor.

1. NAME OF SCHOOL DISTRICT:

2. NAME : LAST FIRST M.I.

3. WHAT HAPPENED? (If a diagram drawing helps, draw on the back of the form)

4. NAMES OF WITNESSES: (Persons present at the time of injury)

5. LOCATION OF ACCIDENT:

6. HOW WERE YOU HURT?

7. WHAT IS YOUR INJURY?

8. DATE OF INJURY:

9. TIME OF INJURY: _____ AM _____ PM

10. DID YOU SEEK MEDICAL ATTENTION? YES_____ NO_____

11. PHYSICIAN'S NAME, ADDRESS, AND TELEPHONE:

12. HOSPITAL OR CLINIC NAME, ADDRESS, AND TELEPHONE:

13. WHO ACCOMPANIED YOU TO THE HOSPITAL OR CLINIC?

NAME: _____

A SCHOOL DISTRICT EMPLOYEE? YES_____ NO_____

14. DATE REPORT RECEIVED AND NAME OF PERSON RECEIVING REPORT:

(When this form is sent to the ASBSD, it must be accompanied by the Employer's First Report of Injury)

SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION

DIVISION OF LABOR AND MANAGEMENT

Tel: 605.773.3681 dlr.sd.gov

FIRST REPORT OF INJURY

GENERAL INSTRUCTIONS

EMPLOYEE

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

EMPLOYER

1. Complete all questions in the EMPLOYER/EMPLOYMENT sections.
2. Sign the form.
3. 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. Give a copy of the form to the injured employee.
5. 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

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

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

00	Not applicable
01	Allergy
02	Disfigurement
71	Occupational disease
72	Hearing loss

SD EForm - 1830 V2

South Dakota Employer's First Report of Injury

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:

Medical Practitioner, 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 _____

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 _____

Telephone Number _____

Policy Number _____

Effective Dates _____

Adjuster/Contact Person _____

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

DLR-LM-101

Revised 11/2018

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