

## **NOTICE: ALABAMA WORKERS COMPENSATION**

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**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](http://berkleynet.com)

Email: [claimops@berkleynet.com](mailto:claimops@berkleynet.com)

Address: 9301 Innovation Drive, Suite 200, Manassas, VA 20110

Phone: 877.497.2637

Fax: 866.275.6320

**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			ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1			10. Mailing Address 1		
6. Physical Address 2			11. Mailing Address 2 or Telephone Number		
7. City	8. State	9. Zip	12. City	13. State	14. Zip
15. Federal ID Number		16. U.C. Account Number		17. NAICS	
INSURER / FILING OFFICE					
18. Insurer Name		21. Filing Office Name		21a. Service Co. #	
19. Insurer Federal ID Number		22. Mailing Address 1			
20. Type Insurer <input type="checkbox"/> Insurance Co. Ins Co #		23. Mailing Address 2 or Telephone Number			
<input type="checkbox"/> Self-Insurer SI #		24. City		25. State	26. Zip
<input type="checkbox"/> Group Fund GF #		27. Filing Office Federal ID Number			
EMPLOYEE / WAGES					
28. First Name			32. Employee ID Number		
29. Middle Name			33. Type Employee ID Number		
30. Last Name			SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)			Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1			40. Gender		41. Date of Birth
35. Mailing Address 2			Male <input type="checkbox"/>		42. Nbr of Dependents
36. City			Female <input type="checkbox"/>		
37. State			38. Zip		39. Phone
43. Marital Status					44. Date Hired
Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>					
45. Occupation Description				46. Number of Days Worked Per Week	
47. Wages \$		49. Received Full Pay For Day of Injury?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>		50. Did Salary Continue?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
INJURY / TREATMENT					
51. Date of Injury		52. Time of Injury		53. Time Employee Began Work	
		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
54. Date Disability Began				55. Date of Death	
PLACE OF ACCIDENT, INJURY, OR EXPOSURE				61. Injury Occurred on Employer's Premises?	
56. Site Address				Yes <input type="checkbox"/> No <input type="checkbox"/>	
57. City				62. Date Employer Notified	
58. State				59. Zip	
60. County					
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.)					
64. Nature of Injury Code					
65. Part of Body Code		66. Cause of Injury Code			
67. Initial Treatment					
No Medical Treatment <input type="checkbox"/>		First Aid By Employer <input type="checkbox"/>		68. Name of Treatment Facility	
Minor Clinic / Hospital <input type="checkbox"/>		Emergency Room <input type="checkbox"/>		69. Address	
Hospitalized > 24 Hours <input type="checkbox"/>		Major medical/Lost time <input type="checkbox"/>		70. City	
Hospitalized Overnight <input type="checkbox"/>				71. State	
				72. Zip	
73. Name of Physician or Other Health Care Professional			74. Has Injured Returned to Work		If so, 75. Date
			Yes <input type="checkbox"/> No <input type="checkbox"/>		76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
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.**