

WC Form 2
Rev. 1-93

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

OMBUDSMAN 1-800-528-5166

Send to: Your workers' compensation insurance carrier, in duplicate

PRINT OR TYPE

EMPLOYER	1. EMPLOYER'S NAME AND MAILING ADDRESS (As shown on Insurance Policy or S. I. Certificate) (No. & Street, City, County, State, ZIP) TALLADEGA COLLEGE 627 WEST BATTLE STREET TALLADEGA, AL 35160 TELEPHONE NUMBER 9256-362-0206		LOCATION, IF DIFFERENT FROM MAILING ADDRESS		Do Not Write In The Space Below Employer U. C. ← Carrier Number ← SIC Carrier-Fund Soc. Sec. No. ← Sex Marital Status Dependents Age Occupation Event County On Premises Event Date Paid Day Injury Employer Knew Injury Source Accident Type Nature of Injury Part of Body Date of Death Stopped Work Time Employed Time in Job Weekly Wage Report Date Report Received Back to Work Case Class
	2. EMPLOYER IDENTIFICATION (U. C. ACCOUNT) NUMBER NT07893600		3. CARRIER OR SELF-INSURANCE REGISTRATION NUMBER		
	4. NATURE OF BUSINESS (Manufacturing, Trade, Transportation, etc.) EDUCATION		SPECIFIC PRODUCTS		
	5. WORKERS' COMPENSATION PROVIDED BY: INSURANCE CARRIER () SELF-INSURANCE () GROUP FUND (X) IF INSURANCE CARRIER, GIVE NAME AND ADDRESS: Employer's Claim Management, Inc. P.O. Box 5614, Montgomery, AL 36103-5614 50085				
	6. EMPLOYEE'S NAME (Last) (First) (Middle)		7. SEX MALE () FEMALE ()	8. AGE	
EMPLOYEE	10. EMPLOYEE'S HOME ADDRESS (No. & Street or RFD, City, County, State, ZIP)		11. MARITAL STATUS: SINGLE () MARRIED () DIVORCED () SEPARATED () WIDOWED ()		
	12. HOME TELEPHONE	13. REGULAR OCCUPATION		14. WORKING IN WHAT DEPARTMENT WHEN HURT	
	15. PLACE OF ACCIDENT OR EXPOSURE (Address or location, include County)			16. ON EMPLOYER'S PREMISES? YES () NO ()	
	17. Date of Occurrence	18. TIME OF DAY a.m. () p.m. ()	19. Date Disability Began	20. Date Employer Notified	
INJURY OR ILLNESS	21. DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED. (E.g., amputation of right index finger at second joint, fracture of 2 ribs, lead poisoning, dermatitis of left hand, etc.)				
	22. IF FATAL, GIVE DATE OF DEATH				
	23. WHAT THING DIRECTLY PRODUCED THIS INJURY OR ILLNESS? (Name object struck against or struck by; vapor, poison, chemical or radiation; if strain or hernia, the thing being lifted, pulled, pushed, etc.; if injury resulted solely from bodily motion, the stretching, twisting, etc. which resulted in injury.)				
	24. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Begin by telling what the employee was doing just before the accident or exposure. Be specific. If employee was using tools or equipment, or handling material, name them and tell what employee was doing with them.) (Now describe fully the events which resulted in injury or illness. Tell what happened and how it happened. Specify how objects or substances were involved. Give full details of all factors which led or contributed to the accident or exposure.)				
	25. NAME AND ADDRESS OF TREATING PRACTITIONER		NAME AND ADDRESS OF HOSPITAL HOSPITALIZED () OUT-PATIENT () EMERGENCY TREATMENT ()		
WAGE INFORMATION	26. Has Injured Returned to Work? Yes () No ()	27. If so, Date	28. At What Wage?	29. At What Occupation?	
	30. LENGTH OF TIME IN YOUR EMPLOY? Years _____ Months _____		31. LENGTH OF TIME IN PRESENT JOB Years _____ Months _____	32. NUMBER OF DEPENDENTS	
	33. Average Weekly Wage	34. Weekly Value of Remuneration Other Than Wages-(Food, Lodging, etc.) \$		35. DID EMPLOYEE RECEIVE FULL PAY FOR DAY OF INJURY? YES () NO ()	
	36. Date of This Report	37. Signed by	38. Signature	39. Official Position or Title	