Employer's First Report of Injury

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

TO BE FILLED OUT BY EMPLOYER

Submit Report to: BERKLEY RISK ADMINISTRATORS COMPANY, LLC
PO BOX 59143
MINNEAPOLIS, MN 55459-0143

Complete and return this report to Leech Lake Health and Safety within 24 hours of injury.

EMPLOYER INFORMATION			
Agreement Number 89-20	Policy Period 7/1/2023 to 6/30/2024	Nature of Business (Tribal Government, Casino, Etc) TRIBAL GOVERNMENT	
Insured Name and Address		Fax: 218-335-7070 Leech Lake Health and Safety Contact email healthandsafety@leechlakegaming.com	
Name of Person Completing Report	Title of Person Completing Form	Signature of Person Completing Form	Date Completed

EMPLOYEE INFORMATION					
Last Name	First	M.I.	Social Security Number	Sex	Birth Date
Home Address (Number & Street)	City	State	Zip Code		Phone No.
Employee's Job Title When Injured		Employee's Assigned Department			

DESCRIPTION OF ACCIDENT				
Date of Injury	Time of Injury	Last Day of Work After Injury	Date of Return to Work	Date Employer Notified of Injury
Address or Location of Accident	City	State	Zip Code	On Employer Premises?
Was Injury Fatal?	Nature of Injury (Scratch, Cut, Etc.)		Part of Body Injured	
Emergency Room, Hospital or Medical Facility Treated by (Name, Address & Phone)			Attending Physician (Name)	
How Did Accident Happen? What Was Employee Doing When Accident Occurred? (State All Details, Use Other Side if Needed)				
If Validity of Claim Is Doubted, State Reason				

EMPLOYEE'S WAGE DATA					
Was Worker in Your Employ When Injured	Date of Last Hire	Hours Per Day Employee Worked From To	Number of Days Per Week:	Employee Usually Works	Business Usually Works
Employee's Wage $	Per ☐ Hour ☐ Day ☐ Week ☐ Month				
Actual Gross Earnings For the 30 Calendar Days Preceding Injury $	Gross Wages of Employee During 12 Months Preceding Injury; or if Employee Worked Less Than 12 Months, Gross Wages From Date of Hire through Day Prior to Injury	From To $			

This form does not guarantee payment of benefits

BRAC 9530 (9/00)