STATE OF ALABAMA

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

FAX COMPLETED FORM TO (205) 991-7978

CLAIM REFERENCE

FEDERAL TAX ID NUMBER (REQUIRED):	INSURED POLICY NUMBER:
63-0781490	*600-2017-02962-0*

EMPLOYER

Employer Business Name: *Weil Wrecker Service* Physical Address 1: *3400 2nd Ave South* Physical Address 2: City: *Birmingham* State: *AL* Zip: *35222*	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS: Mailing Address 1: *3400 2nd Ave South* Mailing Address 2: City: *Birmingham* State: *AL* Zip: *35222*

INSURER / FILING OFFICE

Insurer Name: *Sheffield Risk Management* Mailing Address: *1800 Corporate Drive* City: *Birmingham* State: *AL* Zip: *35242*	Filing Office Phone Number: *(205) 991-7552* Filing Office Fax Number: *(205) 991-7978*

EMPLOYEE / WAGES

First Name: Middle Name: Last Name: Last Name Suffix:	**EMPLOYEE SSN**: **DATE OF BIRTH**:	
Mailing Address 1: Mailing Address 2: City: State: Zip: 39. Phone:	Gender: Male ☐ Female ☐	**Date of Hire:**
Marital Status: Unmarried (Single/Divorced/Widowed) ☐ Married ☐ Separated ☐ Unknown ☐		Nbr of Dependents:
Occupation Description:		**#** of Days Worked Per Week:
Wages: $ # of Hours Worked Per Week: Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐	Received Full Pay For Day of Injury? Yes ☐ No ☐ Did Salary Continue After Incident? Yes ☐ No ☐	

INJURY / TREATMENT

DATE OF INJURY:	Time of Injury: a.m. ☐ p.m. ☐ unk ☐	Time Employee Began Work: a.m. ☐ p.m. ☐	Date Disability Began:	Date of Death:

PLACE OF ACCIDENT, INJURY, OR EXPOSURE: Site Address: City: State: Zip: County:	Injury Occurred on Employer's Premises? Yes ☐ No ☐ **Date Employer Notified:**

DESCRIBE IN DETAIL WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT, HOW THE INJURY OCCURRED AND BODY PARTS AFFECTED:

Initial Treatment:
No Medical Treatment ☐ First Aid By Employer ☐ Minor Clinic ☐ Emergency Room ☐ Hospitalized > 24 Hours ☐

Name of Treatment Facility/Physician: UAB - The Workplace
Address: 1201 11th Ave S, Suite 100 City: Birmingham State: AL Zip: 35205

Has Injured Returned to Work? Yes ☐ No ☐	**Date Injured Returned to Work:**

OTHER

Date Prepared:	Preparer's First Name: Last Name: Title:	Preparer's Phone: *205.251.4060* Preparer's Fax: *205.251.7010* Preparer's E-mail: *sharon@weilwrecker.com*

10.29.14