

Section Name	Field Name	Field and/or Section Description
<b>TITLE</b> <b>ACORD 4 (2011/07)</b>	<b>Workers Compensation - First Report of Injury or Illness</b>	<p>The title of the form. ACORD 4, Workers Compensation First Report of Injury or Illness, is used to report a work-related injury. ACORD, in conjunction with the IAIABC (International Association of Industrial Accident Boards &amp; Commissions) developed this standard First Report. The form tracks with the IAIABC and ANSI X12 EDI standard for reporting Workers Compensation losses.</p> <p>The form is designed as a first notice of a claim for injury or illness by an employee. In nearly all cases, the form is completed by the employer and sent directly to the insurer or to the state workers compensation board. It contains information about the employer, insurance carrier, employee, the occurrence leading to the injury or illness, and the nature of injury or illness. The second and third pages of the form contain required state specific fraud warnings. Instructions to the employer regarding completion of the form are contained on the fourth and fifth pages of the form.</p> <p>Although the form is accepted by insurers in all states, each jurisdiction mandates the form to be used within that state with respect to the report made to the workers compensation board. This version of ACORD 4 is accepted in many jurisdictions. It is anticipated that this number will continue to increase significantly as states adopt the IAIABC and ANSI X12 EDI Standard.</p>
<b>IDENTIFICATION SECTION</b>	<b>Employer (Name &amp; Address incl Zip)</b>	Enter text: The named insured(s) as it/they will appear on the policy declarations page.
<b>IDENTIFICATION SECTION</b>	<b>Address 1</b>	Enter text: The named insured's mailing address line one.
<b>IDENTIFICATION SECTION</b>	<b>Address 2</b>	Enter text: The named insured's mailing address line two.
<b>IDENTIFICATION SECTION</b>	<b>City</b>	Enter text: The named insured's mailing address city name.
<b>IDENTIFICATION SECTION</b>	<b>State</b>	Enter code: The named insured's mailing address state or province code.
<b>IDENTIFICATION SECTION</b>	<b>Zip</b>	Enter code: The named insured's mailing address postal code.
<b>IDENTIFICATION SECTION</b>	<b>Industry Code</b>	Enter code: The Standard Industry Classification code assigned to the business activity (if known). This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

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IDENTIFICATION SECTION	Employer FEIN	Enter identifier: The tax identifier of the named insured.
IDENTIFICATION SECTION	Carrier / Administrator Claim Number *	Enter identifier: The identifier assigned to the claim by the insurer. As used here, the employer should not enter data in this field.
IDENTIFICATION SECTION	Report Purpose Code *	Enter code: The code identifying the purpose of the report. This code is entered by the carrier or the state workers comp board that receives the form. As used here, the employer should not enter data in this field.
IDENTIFICATION SECTION	Jurisdiction *	Enter code: The state or organization that has final disposition of this claim. The source of this code list is the U.S. Postal service except for injuries/Illness under Federal Jurisdiction which use the Workers' Compensation Insurance Organizations (WCIO) Code list. As used here, the employer should not enter data in this field.
IDENTIFICATION SECTION	Jurisdiction Log Number *	Enter identifier: The identifier assigned to the claim by the jurisdiction. As used here, the employer should not enter data in this field.
IDENTIFICATION SECTION	Insured Report Number	Enter identifier: The identifier assigned to the claim by the named insured/employer.
IDENTIFICATION SECTION	OSHA Case Number	Enter identifier: The case number assigned by OSHA (Occupational Safety and Health Administration), if applicable.
IDENTIFICATION SECTION	Employer's Location Address (If different)	Enter text: The first address line of the physical location.
IDENTIFICATION SECTION	Address 2	Enter text: The second address line of the physical location.
IDENTIFICATION SECTION	City	Enter text: The city of the physical location.
IDENTIFICATION SECTION	State	Enter code: The state or province of the physical location.
IDENTIFICATION SECTION	Zip	Enter code: The postal code of the physical location.
IDENTIFICATION SECTION	Location #	Enter number: The producer assigned number of the location.
IDENTIFICATION SECTION	Phone #	Enter number: The primary phone number of the location.
CARRIER / CLAIMS ADMINISTRATOR	Carrier (Name and Address)	Enter text: The insurer's full legal company name(s) as found in the file copy of the policy. Use the actual name of the company within the group to which the policy has been issued. This is not the insurer's group name or trade name. As used here, this is the licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

Section Name	Field Name	Field and/or Section Description
CARRIER / CLAIMS ADMINISTRATOR	Address 1	Enter text: The first line of the insurer's mailing address.
CARRIER / CLAIMS ADMINISTRATOR	Address 2	Enter text: The second line of the insurer's mailing address.
CARRIER / CLAIMS ADMINISTRATOR	City	Enter text: The city of the insurer's mailing address.
CARRIER / CLAIMS ADMINISTRATOR	State	Enter code: The state or province of the insurer's mailing address.
CARRIER / CLAIMS ADMINISTRATOR	Zip	Enter code: The postal code of the insurer's mailing address.
CARRIER / CLAIMS ADMINISTRATOR	Phone (A/C, No, Ext)	Enter number: The primary phone number of the insurer. As used here, the telephone number of the licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant. (Include area code and extension if applicable)
CARRIER / CLAIMS ADMINISTRATOR	Policy Period Start	Enter date: The effective date of the policy. The date that the terms and conditions of the policy commence.
CARRIER / CLAIMS ADMINISTRATOR	Policy Period Expire	Enter date: The date on which the terms and conditions of the policy will expire.
CARRIER / CLAIMS ADMINISTRATOR	Self Insurance Checkbox	Check the box (if applicable): Indicates if the insured is self-insured, in whole or in part.
CARRIER / CLAIMS ADMINISTRATOR	Claims Administrator (Name, Address & Phone No.)	Enter text: The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.
CARRIER / CLAIMS ADMINISTRATOR	Address 1	Enter text: The first address line of the claim administrator's mailing address.
CARRIER / CLAIMS ADMINISTRATOR	Address 2	Enter text: The second address line of the claim administrator's mailing address.
CARRIER / CLAIMS ADMINISTRATOR	City	Enter text: The city of the claim administrator's mailing address.
CARRIER / CLAIMS ADMINISTRATOR	State	Enter code: The state or province code of the claim administrator's mailing address.
CARRIER / CLAIMS ADMINISTRATOR	Zip	Enter code: The postal code of the claim administrator's mailing address.
CARRIER / CLAIMS ADMINISTRATOR	Phone (A/C, No, Ext)	Enter number: The primary phone number of the claim administrator.
CARRIER / CLAIMS ADMINISTRATOR	Carrier FEIN *	Enter identifier: The tax identifier of the insurer.

Section Name	Field Name	Field and/or Section Description
CARRIER / CLAIMS ADMINISTRATOR	Policy/Self-Insured Number	Enter identifier: The identifier assigned by the insurer to the policy, or submission, being referenced exactly as it appears on the policy, including prefix and suffix symbols. If required for self-insurance, the self-insured license or contract number.
CARRIER / CLAIMS ADMINISTRATOR	Administrator FEIN *	Enter identifier: The tax identifier of the claim administrator.
CARRIER / CLAIMS ADMINISTRATOR	Agent Name	Enter text: The full name of the producer/agency.
CARRIER / CLAIMS ADMINISTRATOR	Agent Code Number	Enter code: The identification code assigned to the producer (e.g. agency or brokerage firm) by the insurer. As used here, this information can be found on your insurance policy.
EMPLOYEE / WAGE	Name	Enter text: The employer's last name (surname).
EMPLOYEE / WAGE	First Name	Enter text: The employee's first name (given name).
EMPLOYEE / WAGE	Middle Initial	Enter text: The employee's middle name or initial (other given name).
EMPLOYEE / WAGE	Address (Incl Zip)	Enter text: The first address line of the employee's mailing address.
EMPLOYEE / WAGE	City	Enter text: The city of the employee's mailing address.
EMPLOYEE / WAGE	State	Enter code: The state or province code of the employee's mailing address.
EMPLOYEE / WAGE	Zip	Enter code: The postal code of the employee's mailing address.
EMPLOYEE / WAGE	E-Mail Address	Enter text: The e-mail address for the employee.
EMPLOYEE / WAGE	Phone	Enter number: The primary phone number of the employee.
EMPLOYEE / WAGE	Date of birth	Enter date: The employee's birth date.
EMPLOYEE / WAGE	Social Security Number	Enter identifier: The tax identifier of the employee.
EMPLOYEE / WAGE	Date Hired	Enter date: The hire date of the employee.
EMPLOYEE / WAGE	State of Hire	Enter code: The state in which the individual was hired.
EMPLOYEE / WAGE	Sex - Male	Check the box (if applicable): Indicates the employee is male.
EMPLOYEE / WAGE	Sex - Female	Check the box (if applicable): Indicates the employee is female.
EMPLOYEE / WAGE	Sex - Unknown	Check the box (if applicable): Indicates the gender of the employee is unknown.
EMPLOYEE / WAGE	# of Dependents	Enter number: The number of dependents of the employee.
EMPLOYEE / WAGE	Marital Status - Unmarried/Single/Divorced	Check the box (if applicable): Indicates the employee is single.
EMPLOYEE / WAGE	Married	Check the box (if applicable): Indicates the employee is married.
EMPLOYEE / WAGE	Separated	Check the box (if applicable): Indicates the employee is separated from their spouse.
EMPLOYEE / WAGE	Unknown	Check the box (if applicable): Indicates the employee's marital status is unknown.
EMPLOYEE / WAGE	Occupation / Job Title	Enter text: The occupation of the employee. As used here, the occupation of the employee at the time of the accident or exposure.

Section Name	Field Name	Field and/or Section Description
EMPLOYEE / WAGE	Employment Status	Enter code: Identifies the employment status of this individual. The valid choices are: Full-Time, Part-Time, Not Employed, Officer, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-Time, Apprenticeship Part-Time, Volunteer, Seasonal and Piece Worker.
EMPLOYEE / WAGE	NCCI Class Code *	Enter code: The rating classification code that the employee's estimated remuneration was assigned to.
EMPLOYEE / WAGE	Rate	Enter amount: The employee's average wage amount. As used here, the rate at the time of the accident or exposure.
EMPLOYEE / WAGE	Day	Check the box (if applicable): Indicates the average wage amount is paid per day.
EMPLOYEE / WAGE	Week	Check the box (if applicable): Indicates the average wage amount is paid per week.
EMPLOYEE / WAGE	Month	Check the box (if applicable): Indicates the average wage amount is paid monthly.
EMPLOYEE / WAGE	Other (checkbox)	Check the box (if applicable): Indicates the average wage amount is paid at a frequency other than those listed.
EMPLOYEE / WAGE	Other (blank field)	Enter code: Indicates the frequency at which the average wage amount is paid.
EMPLOYEE / WAGE	Average Weekly Wages	Enter amount: The average weekly wages for the past 52 weeks.
EMPLOYEE / WAGE	# Days Worked / Week	Enter number: The number of days worked per week.
EMPLOYEE / WAGE	Full Pay for Day of Injury?	Enter Y for a "Yes" response. Input N for "No" response. Indicates if the injured/ill employee will be paid for the full day of the injury/illness.
EMPLOYEE / WAGE	Did salary continue?	Enter Y for a "Yes" response. Input N for "No" response. Indicates if salary continuance applies.
OCCURRENCE / TREATMENT	Time Employee Began Work	Enter time: The time of day that work began for the employee on the day of the injury/illness.
OCCURRENCE / TREATMENT	A.M.	Check the box (if applicable): Indicates the employee began work in the morning.
OCCURRENCE / TREATMENT	P.M.	Check the box (if applicable): Indicates the employee began work in the afternoon or evening.
OCCURRENCE / TREATMENT	Date of Injury / Illness	Enter date: The date that the loss occurred. As used here, the date the claimant actually sustained the injury or exposure (which is the date that the loss occurred).
OCCURRENCE / TREATMENT	Cannot Be Determined	Check the box (if applicable): Indicates the incident time could not be determined.
OCCURRENCE / TREATMENT	Time of Occurrence	Enter time: The approximate time that the loss occurred.
OCCURRENCE / TREATMENT	A.M.	Check the box (if applicable): Indicates the loss occurred in the morning.
OCCURRENCE / TREATMENT	P.M.	Check the box (if applicable): Indicates the loss occurred in the afternoon or evening.

<b>Section Name</b>	<b>Field Name</b>	<b>Field and/or Section Description</b>
<b>OCCURRENCE / TREATMENT</b>	<b>Last work date</b>	Enter date: The date on which the employee last worked.
<b>OCCURRENCE / TREATMENT</b>	<b>Date Employer Notified</b>	Enter date: The date the employer was notified or became aware of the employee's work related disability/incapacity.
<b>OCCURRENCE / TREATMENT</b>	<b>Date Disability Began</b>	Enter date: The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise stated by statute.
<b>OCCURRENCE / TREATMENT</b>	<b>Contact Name</b>	Enter text: The full name (First, Middle, Last) of the individual to be contacted as a representative of the insured on all subsequent business relating to this incident. No entry is needed if the 'Contact Insured' option is checked.
<b>OCCURRENCE / TREATMENT</b>	<b>Phone (A/C, No, ext)</b>	Enter number: The loss contact's primary telephone number including area code.
<b>OCCURRENCE / TREATMENT</b>	<b>Type of Injury / Illness</b>	Enter text: The description of the nature of the injury or illness being reported.
<b>OCCURRENCE / TREATMENT</b>	<b>Part of Body Affected</b>	Enter text: The description of the part of the body to which the injury occurred.
<b>OCCURRENCE / TREATMENT</b>	<b>Did Injury / Illness Exposure Occur on Employer's Premises?</b>	Enter Y for a "Yes" response. Input N for "No" response. Indicates if the accident, injury or illness occurred on the employer's premises.
<b>OCCURRENCE / TREATMENT</b>	<b>Type of Injury / Illness Code *</b>	Enter code: The industry code that corresponds to the nature of the injury sustained by the claimant.
<b>OCCURRENCE / TREATMENT</b>	<b>Part of Body Affected Code *</b>	Enter code: The industry code that corresponds to the affected body part.
<b>OCCURRENCE / TREATMENT</b>	<b>Department or Location Where Accident or Illness Exposure Occurred</b>	Enter text: The department or location where accident or illness exposure occurred (e.g., maintenance department or client's office at 452 Monroe St., Washington, DC 26210). If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.
<b>OCCURRENCE / TREATMENT</b>	<b>All Equipment, Materials, or Chemicals Employee was Using When Accident or Illness Exposure Occurred</b>	Enter text: The description of all equipment, materials, or chemicals employee was using when accident or illness exposure occurred (e.g., acetylene cutting torch, metal plate). List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush and paint. Enter "NA" for not applicable if no equipment, materials or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

<b>Section Name</b>	<b>Field Name</b>	<b>Field and/or Section Description</b>
<b>OCCURRENCE / TREATMENT</b>	<b>Specific Activity the Employee Was Engaged in When the Accident or Illness Exposure Occurred</b>	Enter text: The specific activity the employee was engaged in when the accident or illness exposure occurred, (e.g., Cutting metal plate for flooring). Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.
<b>OCCURRENCE / TREATMENT</b>	<b>Work Process the Employee Was Engaged in When Accident or Illness Exposure Occurred</b>	Enter text: The work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process, e.g., walking along a hallway.
<b>OCCURRENCE / TREATMENT</b>	<b>How Injury or Illness / Abnormal Health Condition Occurred. Describe the Sequence of events and Include Any Objects or Substances that Directly Injured the Employee or Made the Employee Ill</b>	Enter text: The description of how injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill, (e.g., Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal).
<b>OCCURRENCE / TREATMENT</b>	<b>Cause of Injury Code *</b>	Enter code: The industry code identifying the general cause of loss, occurrence, injury or illness. There are multiple sources for this code list such as the Workers' Compensation Insurance organizations (WCIO), Insurance Services Office (ISO), Bureau of Labor Statistics.
<b>OCCURRENCE / TREATMENT</b>	<b>Date Return(ed) to Work</b>	Enter date: The date the claimant returned to work or is expected to return to work.
<b>OCCURRENCE / TREATMENT</b>	<b>If Fatal, give Date of Death</b>	Enter date: The employee's date of death.
<b>OCCURRENCE / TREATMENT</b>	<b>Were Safeguards or Safety Equipment Provided?</b>	Enter Y for a "Yes" response. Input N for "No" response. Indicates the response to the question, "Were safeguards or safety equipment provided?".
<b>OCCURRENCE / TREATMENT</b>	<b>Were Safeguards Or Safety Equipment Provided Used? - Yes</b>	Enter Y for a "Yes" response. Input N for "No" response. Indicates the response to the question, "Were safeguards or safety equipment provided used?".
<b>OCCURRENCE / TREATMENT</b>	<b>Physician / Health Care Provider (Name and Address)</b>	Enter text: The full name of the physician.
<b>OCCURRENCE / TREATMENT</b>	<b>Address 1</b>	Enter text: The physician's first mailing address line.
<b>OCCURRENCE / TREATMENT</b>	<b>Address 2</b>	Enter text: The physician's second mailing address line.
<b>OCCURRENCE / TREATMENT</b>	<b>City</b>	Enter text: The physician's mailing address city name.

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OCCURRENCE / TREATMENT	State	Enter code: The physician's mailing address state or province code.
OCCURRENCE / TREATMENT	Zip	Enter code: The physician's mailing address postal code.
OCCURRENCE / TREATMENT	Hospital or Offsite Treatment (Name and Address)	Enter text: The name of the hospital.
OCCURRENCE / TREATMENT	Address 1	Enter text: The hospital's mailing address line one.
OCCURRENCE / TREATMENT	Address 2	Enter text: The hospital's mailing address line two.
OCCURRENCE / TREATMENT	City	Enter text: The hospital's mailing address city.
OCCURRENCE / TREATMENT	State	Enter text: The hospital's mailing address state or province code.
OCCURRENCE / TREATMENT	Zip	Enter text: The hospital's mailing address line postal code.
OCCURRENCE / TREATMENT	Initial Treatment - No Medical Treatment	Check the box (if applicable): Indicates there was no initial treatment when the claimant was injured.
OCCURRENCE / TREATMENT	Minor : By Employer	Check the box (if applicable): Indicates the initial treatment was minor and done by the employer.
OCCURRENCE / TREATMENT	Minor Clinic / Hosp	Check the box (if applicable): Indicates the initial treatment was minor and done by a clinic or hospital.
OCCURRENCE / TREATMENT	Emergency Care	Check the box (if applicable): Indicates emergency care was required when the claimant was injured.
OCCURRENCE / TREATMENT	Overnight Hospitalization	Check the box (if applicable): Indicates overnight hospitalization was required when the claimant was injured.
OCCURRENCE / TREATMENT	Future Major Medical / Lost Time Anticipated	Check the box (if applicable): Indicates future major medical/lost time is anticipated for the claimant.
OCCURRENCE / TREATMENT	Witness Name	Enter text: The name of a person that was a witness to the incident or an uninjured passenger. As used here the person who witnessed how the injury, or illness/abnormal health condition occurred.
OCCURRENCE / TREATMENT	Phone (A/C, No. Ext)	Enter number: The primary phone number of a person that was a witness to the incident.
OCCURRENCE / TREATMENT	Witness Name	Enter text: The name of a person that was a witness to the incident or an uninjured passenger. As used here the person who witnessed how the injury, or illness/abnormal health condition occurred.

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<b>OCCURRENCE / TREATMENT</b>	<b>Phone (A/C, No. Ext)</b>	Enter number: The primary phone number of a person that was a witness to the incident.
<b>OCCURRENCE / TREATMENT</b>	<b>Date Administrator Notified</b>	Enter date: The date the employer was notified or became aware of the employee's work related disability/incapacity.
<b>OCCURRENCE / TREATMENT</b>	<b>Date Prepared</b>	Enter date: The date the claim form was completed
<b>OCCURRENCE / TREATMENT</b>	<b>Preparer's Name</b>	Enter text: The name of the individual that prepared the claim form.
<b>OCCURRENCE / TREATMENT</b>	<b>Preparer's Title</b>	Enter text: The title of the individual that prepared the claim form.
<b>OCCURRENCE / TREATMENT</b>	<b>Phone Number</b>	Enter number: The phone number of the individual that prepared the claim form.
<b>SIGNATURE</b>	<b>Signature</b>	Sign here: Accommodates the signature of the employee.
<b>SIGNATURE</b>	<b>Signature</b>	Sign here: Accommodates the signature of the employee.
<b>Edition</b>	<b>Date</b>	The edition identifier of the form including the form number and edition (the date is typically formatted YYYY/MM).