TPA Reference No.	Agency use only Incident No.:	Agency use only Claim No.:	**DAS** **WC-207** ***First Report of Injury***
The Supervisor must complete the DAS WC-207 with the injured worker and then forward the document to the Human Resources/Workers' Compensation Office within 24 hours. Sending the remaining forms (DAS 715, DAS WC-211, WCC Form 1A) is critical for accurate benefit determination.			

1. Agency Location Code	2. Division/Region	3. Name of Injured Worker (First) (Last) (MI)
4. SSN	5. Employee Number	6. Personal Email Address (for ease of contact with WC personnel and Adjuster)

7. Home Address (City or Town) (State) (Zip)	8. Telephone	9. Date of Birth	10. Sex
11. Job Classification (Title)	12. Date of Hire	13. Date of Incident	14. Time of Incident

15. Time Employer Notified	16. Date Employer Notified	17. Time Injured Worker Began Work: _____ AM ☐ PM ☐	18. Was Injury Fatal? YES ☐ NO ☐	19. Date of Fatality

20. How Did the Injury Occur?	
21. Type of Injury	22. Body Part(s) Affected
23. Did Injury Occur on Employer Premises? YES ☐ NO ☐	24. Location Injury Occurred
25. Injured Worker Seeking Medical Treatment YES ☐ NO ☐ If Yes Complete Questions 26-28	26. Medical Care Provided By: (Physician Name and Address)
27. Was Injured Worker Treated in an Emergency Room? YES ☐ NO ☐	28. Was Injured Worker Hospitalized Overnight as an In-Patient? YES ☐ NO ☐

29. Were There Any Witnesses to the Injury? YES ☐ NO ☐ (If yes, give name, address, and phone)
30. To What Supervisor Was Injury Reported? (Name) (Title)

31. Supervisor Contact Info Please Print	Name:
	Work Phone:
	Best Time to Contact:

32. Signature of Supervisor (or other Designated Authority) PRINT NAME: DATE:
33. Date Injury Phoned In To 800-828-2717