First Report of Injury - External

QuickStart Guide

The First Report of Injury is available in CompHub. Complete the four(4)-tab form to complete the electronic FROI and generate the PDF document upon completion.

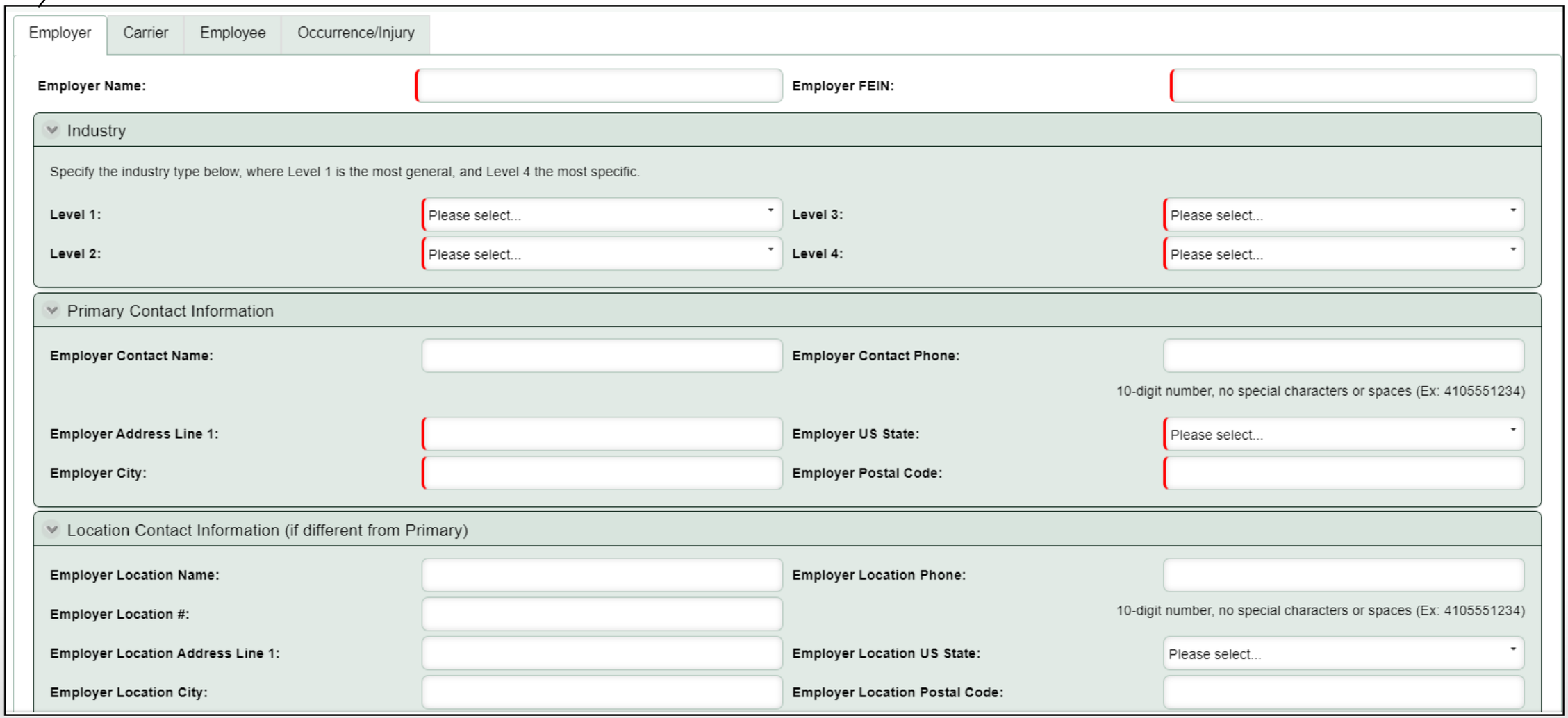
This process is located under ***Start New Action> First Report of Injury***

Workers' Compensation Commission

If there is an existing Claim, make sure to enter the Claim Number in the space provided.

WCC Claim Number, If Known:

1 *Complete the Form using the textboxes, dropdowns, and other controls available to you. Red lines denote required fields but any and all information available should be entered*



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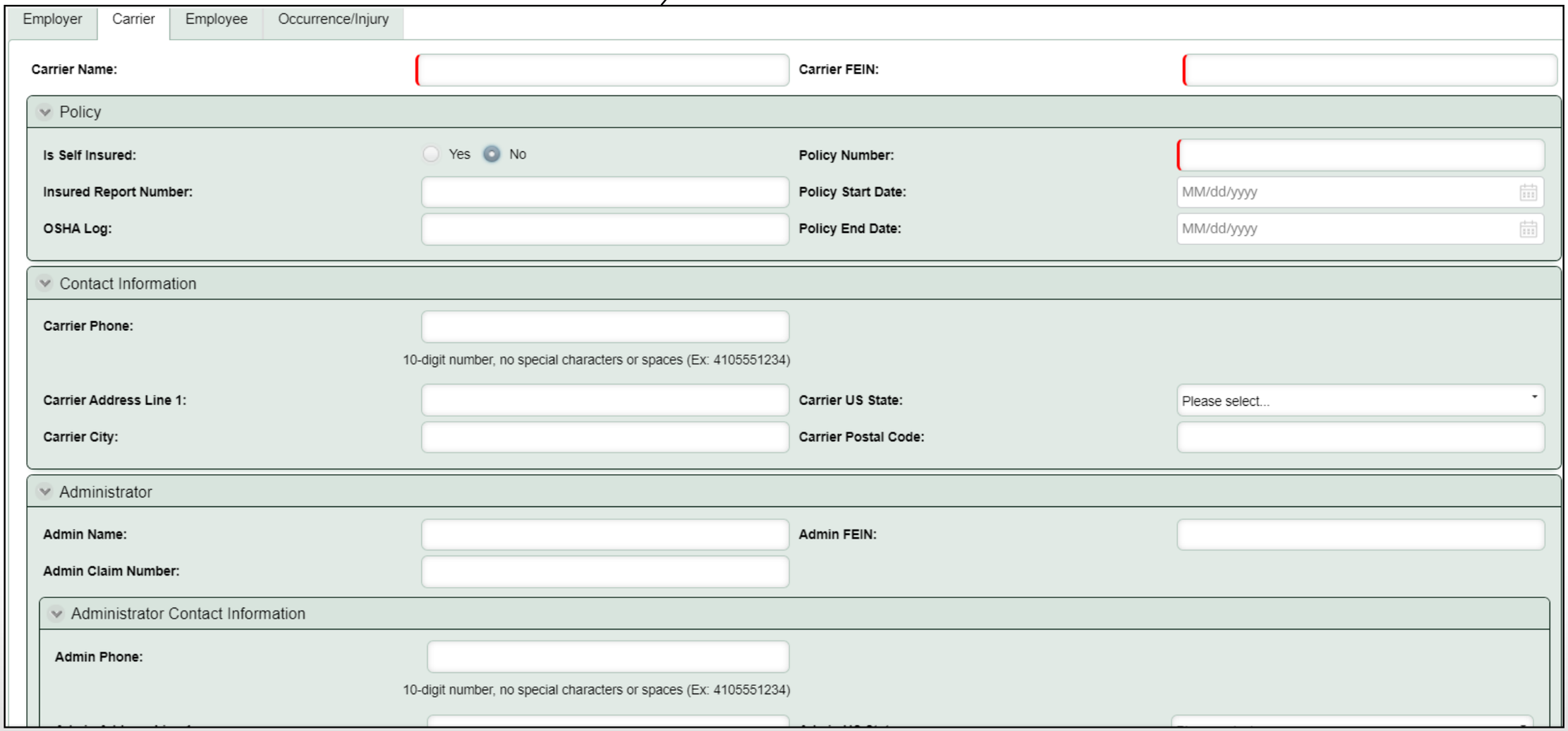
The second tab of the FROI form allows you to enter the Carrier information and designate a Point of Contact.

1 *Complete the Form using the textboxes, dropdowns, and datepickers available to you. Red lines denote required fields but any and all information available should be entered*



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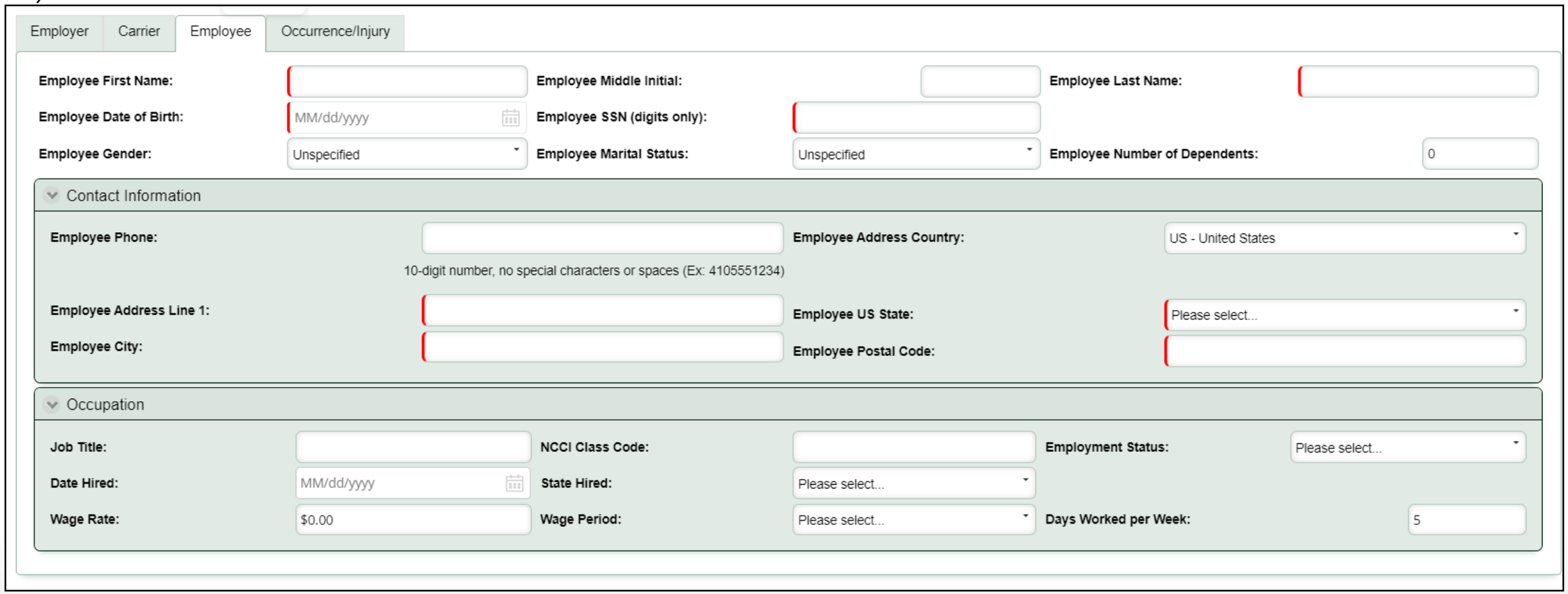
The third tab of the Form allows you to enter the information regarding the Employee

1 *Complete the Form using the textboxes, dropdowns, and datepickers available to you. Red lines denote required fields but any and all information available should be entered*



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The Final tab of the form is for entering the information regarding the Injury.

1 *Complete the Form using the textboxes, dropdowns, and datepickers available to you. Red lines denote required fields but any and all information available should be entered*

Employer | Carrier | Employee | Occurrence/Injury

Type of Loss: Please select...

Timeframe

Date/Time Work Began:	MM/dd/yyyy h:mm tt	**Date/Time of Injury:**	MM/dd/yyyy h:mm tt
Date Employer Notified:	MM/dd/yyyy	**Time Cannot Be Determined:**	☐
Date Administrator Notified:	MM/dd/yyyy		
Date Last Worked:	MM/dd/yyyy		
Date of Death (if fatal):	MM/dd/yyyy		
Date Disability Began:	MM/dd/yyyy	**Was Paid Full Day:**	Yes / No
Date Returned to Work:	MM/dd/yyyy	**Did Salary Continue:**	Yes / No

Injury/Illness Details

Work process the Employee was performing

Specific activity the Employee was performing

All equipment, materials, or chemicals the Employee was using

Was on Premises: Yes / No

Did Safeguards Exist: Yes / No

Were Safeguards Used: Yes / No

Accident Description

Body Parts

No records

+

Nature of Injury L1: Please select...

Nature of Injury L2: Please select...

Cause of Injury L1: Please select...

Cause of Injury L2: Please select...

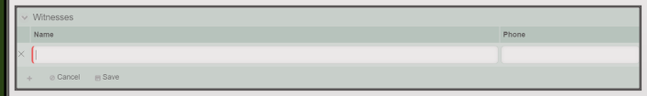
Witnesses

No records

+

To add Body Parts click the Plus(+) Icon and select the Body Part using the dropdown menus. Repeat this until all body parts are added

To add Witnesses click the Plus(+) Icon and type in the name and phone number. Repeat this for any additional witnesses.



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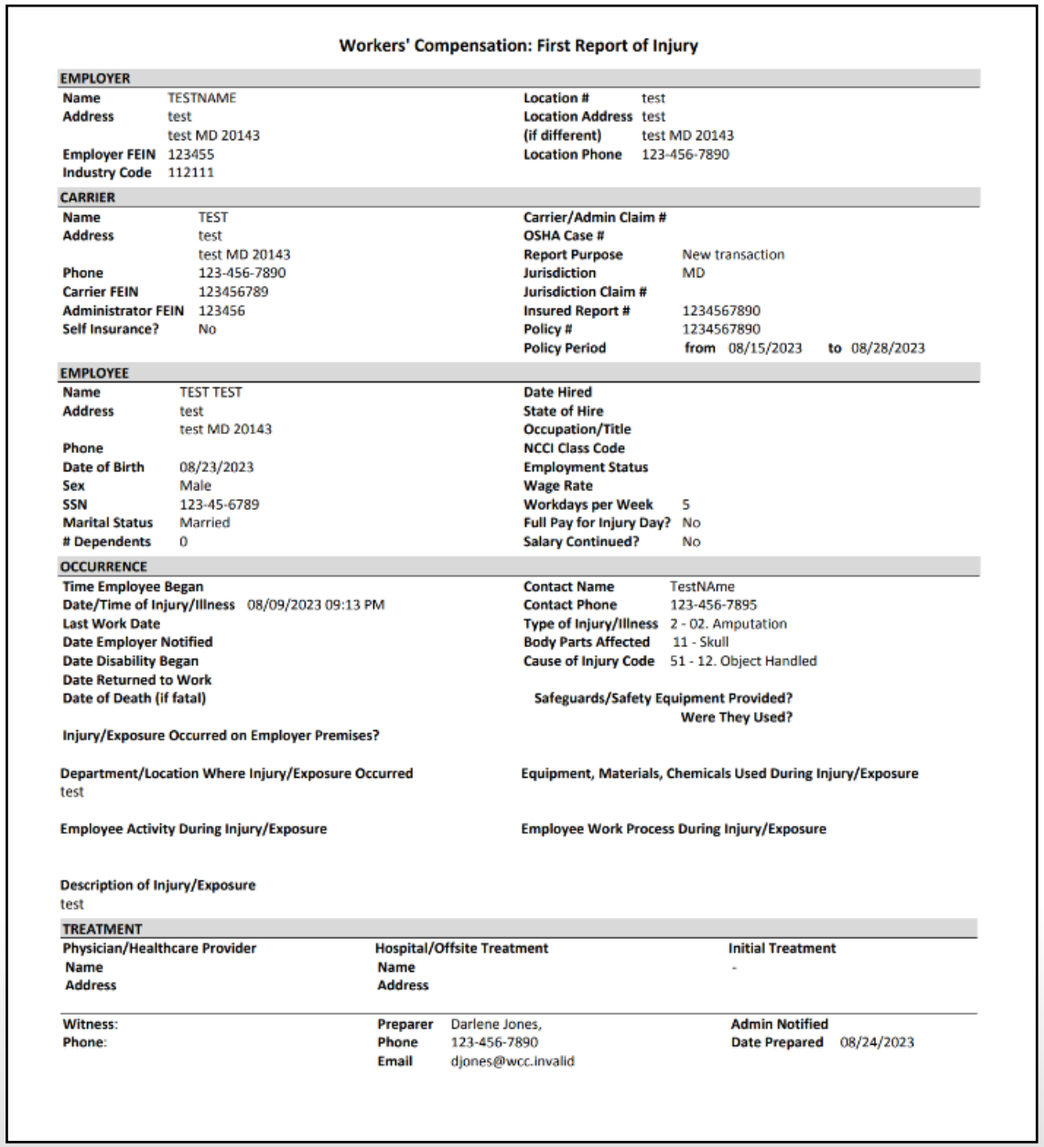
Once Complete, CompHub produces a PDF populated by the information you entered and sends you an email with a link to your submission. It may be a good idea to bookmark the email and/or write down the case number.



Workers' Compensation: First Report of Injury

EMPLOYER

Name	TESTNAME	**Location #**	test
Address	test	**Location Address**	test
	test MD 20143	**(if different)**	test MD 20143
Employer FEIN	123455	**Location Phone**	123-456-7890
Industry Code	112111		

CARRIER

Name	TEST	**Carrier/Admin Claim #**	
Address	test	**OSHA Case #**	
	test MD 20143	**Report Purpose**	New transaction
Phone	123-456-7890	**Jurisdiction**	MD
Carrier FEIN	123456789	**Jurisdiction Claim #**	
Administrator FEIN	123456	**Insured Report #**	1234567890
Self Insurance?	No	**Policy #**	1234567890
		Policy Period	**from** 08/15/2023 **to** 08/28/2023

EMPLOYEE

Name	TEST TEST	**Date Hired**	
Address	test	**State of Hire**	
	test MD 20143	**Occupation/Title**	
Phone		**NCCI Class Code**	
Date of Birth	08/23/2023	**Employment Status**	
Sex	Male	**Wage Rate**	
SSN	123-45-6789	**Workdays per Week**	5
Marital Status	Married	**Full Pay for Injury Day?**	No
# Dependents	0	**Salary Continued?**	No

OCCURRENCE

Time Employee Began		**Contact Name**	TestNAme
Date/Time of Injury/Illness	08/09/2023 09:13 PM	**Contact Phone**	123-456-7895
Last Work Date		**Type of Injury/Illness**	2 - 02. Amputation
Date Employer Notified		**Body Parts Affected**	11 - Skull
Date Disability Began		**Cause of Injury Code**	51 - 12. Object Handled
Date Returned to Work			
Date of Death (if fatal)		**Safeguards/Safety Equipment Provided?**	
		Were They Used?	

Injury/Exposure Occurred on Employer Premises?

Department/Location Where Injury/Exposure Occurred
test

Equipment, Materials, Chemicals Used During Injury/Exposure

Employee Activity During Injury/Exposure

Employee Work Process During Injury/Exposure

Description of Injury/Exposure
test

TREATMENT

Physician/Healthcare Provider	Hospital/Offsite Treatment	Initial Treatment
Name	**Name**	-
Address	**Address**	

Witness:	**Preparer**	Darlene Jones,	**Admin Notified**
Phone:	**Phone**	123-456-7890	**Date Prepared** 08/24/2023
	Email	djones@wcc.invalid	

FROI PDF

Click the case number link to enter CompHub and view your submission.

The Commission has successfully received your FROI submission.

Log into CompHub or click this link: FROI-57 for more details.

E-Notification