

# 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**



**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

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

WCC Claim Number, If Known:

Employer   Carrier   Employee   Occurrence/Injury

**Employer Name:**       **Employer FEIN:**

▼ Industry

Specify the industry type below, where Level 1 is the most general, and Level 4 the most specific.

**Level 1:**       **Level 3:**

**Level 2:**       **Level 4:**

▼ Primary Contact Information

**Employer Contact Name:**       **Employer Contact Phone:**   
10-digit number, no special characters or spaces (Ex: 4105551234)

**Employer Address Line 1:**       **Employer US State:**

**Employer City:**       **Employer Postal Code:**

▼ Location Contact Information (if different from Primary)

**Employer Location Name:**       **Employer Location Phone:**   
10-digit number, no special characters or spaces (Ex: 4105551234)

**Employer Location #:**

**Employer Location Address Line 1:**       **Employer Location US State:**

**Employer Location City:**       **Employer Location Postal Code:**

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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

Employer Carrier **Employee** Occurrence/Injury

**Carrier Name:**  **Carrier FEIN:**

**Policy**

**Is Self Insured:**  Yes  No **Policy Number:**

**Insured Report Number:**  **Policy Start Date:**

**OSHA Log:**  **Policy End Date:**

**Contact Information**

**Carrier Phone:**   
10-digit number, no special characters or spaces (Ex: 4105551234)

**Carrier Address Line 1:**  **Carrier US State:**

**Carrier City:**  **Carrier Postal Code:**

**Administrator**

**Admin Name:**  **Admin FEIN:**

**Admin Claim Number:**

**Administrator Contact Information**

**Admin Phone:**   
10-digit number, no special characters or spaces (Ex: 4105551234)

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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

Employer	Carrier	Employee	Occurrence/Injury			
Employee First Name:	<input type="text"/>	Employee Middle Initial:	<input type="text"/>	Employee Last Name:	<input type="text"/>	
Employee Date of Birth:	<input type="text" value="MM/dd/yyyy"/>	Employee SSN (digits only):	<input type="text"/>			
Employee Gender:	<input type="text" value="Unspecified"/>	Employee Marital Status:	<input type="text" value="Unspecified"/>	Employee Number of Dependents:	<input type="text" value="0"/>	
Contact Information						
Employee Phone:	<input type="text"/>	Employee Address Country:	<input type="text" value="US - United States"/>			
10-digit number, no special characters or spaces (Ex: 4105551234)						
Employee Address Line 1:	<input type="text"/>	Employee US State:	<input type="text" value="Please select..."/>			
Employee City:	<input type="text"/>	Employee Postal Code:	<input type="text"/>			
Occupation						
Job Title:	<input type="text"/>	NCCI Class Code:	<input type="text"/>	Employment Status:	<input type="text" value="Please select..."/>	
Date Hired:	<input type="text" value="MM/dd/yyyy"/>	State Hired:	<input type="text" value="Please select..."/>			
Wage Rate:	<input type="text" value="\$0.00"/>	Wage Period:	<input type="text" value="Please select..."/>		Days Worked per Week:	<input type="text" value="5"/>

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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  Was on Premises:  Yes  No

Specific activity the Employee was performing  Did Safeguards Exist:  Yes  No

All equipment, materials, or chemicals the Employee was using  Were Safeguards Used:  Yes  No

Accident Description  

**Body Parts**

No records

+

Nature of Injury L1: Please select... Cause of Injury L1: Please select...

Nature of Injury L2: 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

Major: Please select...

Minor: Please select...

Specific: Please select...

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

Witnesses

Name	Phone

+

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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			
<b>EMPLOYER</b>			
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		
<b>CARRIER</b>			
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
<b>EMPLOYEE</b>			
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
<b>OCCURRENCE</b>			
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		Safeguards/Safety Equipment Provided?	
Date of Death (if fatal)		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		
<b>TREATMENT</b>			
Physician/Healthcare Provider	Hospital/Offsite Treatment	Initial Treatment	
Name	Name		
Address	Address		
Witness:	Preparer	Admin Notified	
Phone:	Darlene Jones,	Date Prepared	08/24/2023
	123-456-7890		
	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