Non-SEMA4 Employee Details Data Form

Instructions: This form supplements the Injury, Illness, Incident Data Form and is for the collection and reporting of data associated with a work-related, injury, illness or incidents involving employees, volunteers, or student workers that do not have a SEMA4 employment record and work for organizations covered by Risk Management Division's Workers' Compensation Program. Agency Workers' Compensation Coordinators should use this form to gather information to enter the work-related injury, illness or incident into iRISK. Then submit the completed form either by email (preferred method) or signed paper copy to the Workers' Compensation Program. **Do not email directly from web site. Save completed form to your computer, then email. Please note: this form must accompany the completed Injury, Illness, Incident Data Form (IDF).** Other required forms are available at http://mn.gov/admin/government/risk/workers-comp/procedures/

Employee Details

1. Incident date: (MM/DD/YY)	2. First name of injured person:	3. Middle Name:	4. Last name:

5. Social security #:	6. Date of Birth:	7. Gender: ☐Male ☐Female	8. Marital Status: ☐Married ☐Unmarried

9. Current mailing address House number:	10. Street name:	11. City:	12. State	13. Zip code
14. Assigned work location Street number:	15. Street name:	16. City:	17. State	18. Zip code

19. Occupation:	20. Occupation code:	21. Hire date: (MM/DD/YY)	22. Employment type: ☐Full time ☐Intermittent ☐Other ☐Part time ☐Part time ☐Volunteer

23. Employment Status: ☐Emergency ☐Limited ☐Provisional ☐Temporary ☐Unlimited ☐ Unlimited/Academic ☐Intern ☐Non-state ☐Seasonal ☐Trainee ☐Unlimited Academic

24 Work shift wk 1 *(eg M-F 8:00am-4:30pm):*	Wednesday (hours/day)	Tuesday (hours/day)	Friday (hours/day)	Saturday (hours/per)	Sunday (hours/day)	Monday (hours/day)	Tuesday (hours/day)
Work shift wk 2 *(eg M-F 8:00am-4:30pm):*	Wednesday (hours/day)	Tuesday (hours/day)	Friday (hours/day)	Saturday (hours/per)	Sunday (hours/day)	Monday (hours/day)	Tuesday (hours/day)

25. Rate Per Hour:	26 Weekly Base State Salary:

Person completing this form

27. Name:	28. Work phone: ( )	29. Signature:	30. Date:

Insurer: Minnesota Dept. of Administration,
Risk Management Division, Workers' Compensation Program
310 Centennial Office Bldg, 658 Cedar Street
St. Paul, MN 55155
Phone (651) 201-3000

For agency use:

Claimant Name___________________________________

Date of Incident: _________________________________

WC Claim #:_____________________________________