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 must complete this entire form and submit it either by email (preferred method) or signed paper copy to the Workers' Compensation Program via john.sargent@state.mn.us or johnathan.carver@state.mn.us or by fax at 651-297-5471.
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://www.admin.state.mn.us/risk/wc/wcforms.html

Employee Details

1. First name of injured person:	2. Middle initial:	3. Last name:	4. Incident date: (MM/DD/YY)	5. Hire date: (MM/DD/YY)

6. Current mailing address House number:	7. Street name:	8. City:	9. State	10. Zip code

11. Social security #:	12. Date of Birth:	13. Gender: ☐Male ☐Female	14. Marital Status: ☐Married ☐Unmarried

15. Occupation:	16. Occupation code:	17. Employment status: ☐Full time ☐Part time ☐Volunteer ☐Other ☐Intermittent ☐Seasonal ☐Temporary

18 Work shift wk 1 *(eg M-F 8:00am-4:30pm):*	19. Pay per hour:	20. Hours per day:	21. Days per week:	22. Average weekly wage:
Work shift wk 2 *(eg M-F 8:00am-4:30pm):*	23. Base salary:	24. Weekly meals:	25. Weekly lodging:	

Person completing this form

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

Insurer: Minnesota Dept. of Administration,
Risk Management Division, Workers' Compensation Program
P.O. Box 64081, St. Paul, MN 55164-0081
Phone (651) 201-3000

Non-SEMA4 Employee Details
Data Form rev. 3/1/09

For agency use:

Claimant Name_____

Date of Incident: _____

WC Claim #:_____