STATE OF MISSOURI
OFFICE OF ADMINISTRATION
RISK MANAGEMENT SECTION

INITIAL INJURY REPORT (FORM O)

CENTRAL ACCIDENT REPORTING OFFICE (CARO)
P.O. BOX 809
JEFFERSON CITY, MO 65102
573/751-2837 FAX: 573/751-5262
1-888-622-7694

This form **must be completed** for the CARO office to start a workers' compensation file. Please complete and **fax** this form to CARO within 24-48 hours of the injury.

Social Security Number	2. Date of Birth	3. Sex M F
Employee Last Name	First Name	Middle Initial
CARO USE ONLY	5. Injury Case Number	
6. Date of Report	7. Time of Report	
Agency	Division	
Job Title Code	10. Job Title	
11. Semi-Monthly Salary or Hourly Wage (Check appropriate pay status)	12. Salary / Hourly / Volunteer	
13. Location Code	14. Zip Code Where Injury Occurred	
15. County Code Where Injury Occurred		
16. Months in Present Position	17. Date Hired	
18. Days Worked Per Week	19. Shift	20. Day of Week
21. Date of Injury	22. Date Work Day Began	
23. Time of Injury	24. Time Work Day Began	
25. Injury Result in Lost Time? If Yes, complete 26 & 27.		
26. Disability Began Date	27. Disability End Date	
28. Kind of Injury		

29. Medical Care Type Code:

1. Incident Only, No Medical
2. Refused Treatment
3. First Aid Only
4. In-agency Professional Treatment
5. Outside Professional - Doctor
6. Outside Professional - Clinic
7. Outside Professional - Hospital/ER
8. Professional Treatment - Outside Hospital
9. Prosthesis - Eyeglasses, Etc.

30. Agency of Injury Code	31. Part of the Body Code
32. Cause of Injury Code	33. Type of Accident Code
34. Employee at Regular Task?	35. If No, Task Involved
36. Was Weather a Factor?	37. Standard Safety Procedures Followed?

38. Please describe the injury/illness in detail here.

39. Employee Address		
City	State	Zip Code
Employee Phone Number		
40. Person to contact for questions regarding this claim: Name	Phone Number	