

**Cross Reference List for Alabama First Report of Injury Form and IAIABC Releases 1**

**M – Mandatory C – Conditional O – Optional R – Restricted**

**08/31/2007**

<b>AL FIRST REPORT OF INJURY (FROI)</b>				<b>IAIABC REL 1 (148-RCD)</b>		
<b>POS</b>	<b>REQ CODE</b>	<b>FIELD DESCRIPTIONS</b>	<b>LGTH</b>	<b>148-DN</b>	<b>148-LEN</b>	<b>148-POS</b>
01	<b>R</b>	Insured Report Number	25 A/N	DN0026	10 A/N	392-401
02	<b>M</b>	Filing Office Claims Number	25 A/N	DN0015	25 A/N	205-229
03	<b>R</b>	OSHA Log Case Number	25 A/N	n/a	n/a	n/a
04	<b>M</b>	Employer Business Name	40 A/N	DN0018	30 A/N	269-298
05	<b>M</b>	Employer Physical Address 1	40 A/N	DN0019	30 A/N	299-328
06	<b>O</b>	Employer Physical Address 2	40 A/N	DN0020	30 A/N	329-358
07	<b>M</b>	Employer Physical City	15 A/N	DN0021	15 A/N	359-373
08	<b>M</b>	Employer Physical State	2 A/N	DN0022	2 A/N	374-375
09	<b>M</b>	Employer Physical Zip	9 A/N	DN0023	9 A/N	376-384
10	<b>R</b>	Employer Mailing Address 1	40 A/N			
11	<b>R</b>	Employer Mailing Address 2	40 A/N			
12	<b>R</b>	Employer Mailing City	15 A/N			
13	<b>R</b>	Employer Mailing State	2 A/N			
14	<b>R</b>	Employer Mailing Zip	9 A/N			
15	<b>M</b>	Employer Federal ID Number	9 A/N	DN0016	9 A/N	230-238
16	<b>R</b>	Employer U.C Account Number	15 A/N			
17	<b>O</b>	Employer NAICS	6 A/N	DN0025	6 A/N	386-391
18	<b>M</b>	Insurer Name	40 A/N	DN0007	30 A/N	050-079
19	<b>M</b>	Insurer Federal ID Number	9 A/N	DN0006	9 A/N	041-049
20	<b>R</b>	Insurer Type Code	1 A/N			
21	<b>C</b>	Filing Office Name	40 A/N	DN0009	30 A/N	089-118
22	<b>M</b>	Filing Office Mailing Address 1	40 A/N	DN0010	30 A/N	119-148
23	<b>O</b>	Mailing Address 2 or Phone Nbr	40 A/N	DN0011	30 A/N	149-178
24	<b>M</b>	Filing Office Mailing City	15 A/N	DN0012	15 A/N	179-193
25	<b>M</b>	Filing Office Mailing State	2 A/N	DN0013	2 A/N	194-195
26	<b>M</b>	Filing Office Mailing Zip	9 A/N	DN0014	9 A/N	196-204
27	<b>C</b>	Filing Office Federal ID Nbr	9 A/N	DN0008	9 A/N	080-088
28	<b>M</b>	Employee First Name	15 A/N	DN0044	15 A/N	698-712
29	<b>O</b>	Employee Middle Name	15 A/N	DN0045	1 A/N	713-713
30	<b>M</b>	Employee Last Name	40 A/N	DN0043	30 A/N	668-697
31	<b>R</b>	Employee Last Name Suffix	4 A/N			
32	<b>M</b>	Employee ID Number	15 A/N	DN0042	9 A/N	659-667
33	<b>R</b>	Type Employee ID Number	1 A/N			
34	<b>M</b>	Employee Mailing Address 1	40 A/N	DN0046	30 A/N	714-743
35	<b>O</b>	Employee Mailing Address 2	40 A/N	DN0047	30 A/N	744-773
36	<b>M</b>	Employee Mailing City	15 A/N	DN0048	15 A/N	774-788
37	<b>M</b>	Employee Mailing State	2 A/N	DN0049	2 A/N	789-790
38	<b>M</b>	Employee Mailing Zip	9 A/N	DN0050	9 A/N	791-799
39	<b>O</b>	Employee Telephone Number	15 A/N	DN0051	10 A/N	800-809
40	<b>M</b>	Employee Gender	1 A/N	DN0053	1 A/N	818-818
41	<b>O</b>	Employee Date of Birth	8 N	DN0052	8 N	810-817

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42	O	Employee Nbr of Dependents	2 N	DN0055	2 N	820-821
43	M	Employee Marital Status	1 A/N	DN0054	1 A/N	819-819
44	O	Employee Date Hired	8 N	DN0061	8 A/N	874-881
45	O	Employee Occupation Descrip.	50 A/N	DN0060	30 A/N	844-873
46	O	Employee Nr Days Wrk PerWk	1 A/N	DN0064	1 A/N	895-895
47	O	Wages	11 N	DN0062	11 N	882-892
48	O	Wage Period	2 A/N	DN0063	2 A/N	893-894
49	O	Rec'd Full Pay For Injury Day	1 A/N	DN0066	1 A/N	904-904
50	O	Did Salary Continue	1 A/N	DN0067	1 A/N	905-905
51	M	Date of Injury	8 N	DN0031	8 N	463-470
52	R	Time of Injury	4 N	DN0032	4 N	471-474
53	R	Time Employee Began Work	4 N	n/a	n/a	n/a
54	O	Date Disability Began	8 A/N	DN0056	8 A/N	822-829
55	C	Date of Death	8 N	DN0057	8 N	830-837
56	R	Accident Site Address	40 A/N			
57	R	Accident Site City	15 A/N			
58	R	Accident Site State	2 A/N			
59	O	Accident Site Zip	9 A/N	DN0033	9 A/N	475-483
60	R	Accident Site County	20 A/N			
61	M	Injury on Employer's Premises	1 A/N	DN0034	1 A/N	484-484
62	M	Date Employer Notified	8 N	DN0040	8 N	643-650
63	R	Accident Description	500AN	DN0038	150 A/N	491-640
64	M	Nature of Injury Code	2 A/N	DN0035	2 A/N	485-486
65	M	Part of Body Code	2 A/N	DN0036	2 A/N	487-488
66	M	Cause of Injury Code	2 A/N	DN0037	2 A/N	489-490
67	R	Initial Treatment	2 A/N	n/a	n/a	n/a
68	R	Name of Treatment Facility	40 A/N	n/a	n/a	n/a
69	R	Treatment Facility Address	40 A/N	n/a	n/a	n/a
70	R	Treatment Facility City	15 A/N	n/a	n/a	n/a
71	R	Treatment Facility State	2 A/N	n/a	n/a	n/a
72	R	Treatment Facility Zip	9 A/N	n/a	n/a	n/a
73	R	Physician/Health Care Name	40 A/N	n/a	n/a	n/a
74	R	Has Injured Returned to Work	1 A/N	n/a	n/a	n/a
75	O	Returned to Work Date	8 A/N	DN0068	8 A/N	906-913
76	R	Returned to Work Time	4 A/N	n/a	n/a	n/a
77	R	Date Prepared	8 A/N	n/a	n/a	n/a
78	R	Preparer's First Name	15 A/N	n/a	n/a	n/a
79	R	Preparer's Last Name	40 A/N	n/a	n/a	n/a
80	R	Preparer's Title	40 A/N	n/a	n/a	n/a
81	R	Preparer's Telephone Number	15 A/N	n/a	n/a	n/a