

First Report of Injury

See Instructions on Reverse Side
 PRINT or TYPE your responses.
 Enter dates in MM/DD/YYYY format.



DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #		2. OSHA Case #	
3. DATE OF CLAIMED INJURY		4. Time of injury <input type="checkbox"/> am <input type="checkbox"/> pm	5. Time employee began work on date of injury <input type="checkbox"/> am <input type="checkbox"/> pm
6. EMPLOYEE Name (last, first, middle)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried
9. Home Address		10. Home phone #	11. Date of birth
City	State	Zip Code	12. Occupation
13. Regular department		14. Date hired	
15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week
19. Employment Status		<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer	
20. Weekly value of:	Meals	Lodging	2 nd Income
21. Apprentice		<input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Tell us how the injury occurred and what the employee was doing before the incident (give details). Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."			
23. What was the injury or illness (include the part(s) of body)? Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.	
25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, indicate name and address of place of occurrence		26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI
		28. Date employer notified of injury	29. Date employer notified of lost time
		30. Return to work date	31. Date of death
32. TREATING PHYSICIAN (name, address, and phone)		33. HOSPITAL/CLINIC (name and address) (if any)	
		34. Emergency Room Visit <input type="checkbox"/> Yes <input type="checkbox"/> No	
		35. Overnight in-patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
36. EMPLOYER Legal name		37. EMPLOYER DBA name (if different)	
38. Mailing address		39. Employer FEIN	40. Unemployment ID#
City	State	Zip Code	41. Employer's contact name and phone #
42. Physical address (if different)		43. Witness (name and phone)	
City	State	Zip Code	44. NAICS code
		45. Date form completed	
46. INSURER name		51. CLAIMS ADMIN COMPANY (CA) name (check one) <input type="checkbox"/> Insurer <input type="checkbox"/> TPA	
47. Insured legal name		52. CA address	
48. Policy # or self-insured certificate #		City	State Zip Code
49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. Claim #