Updated 12/2018

First Report of Injury

Employee Information

Last Four of Employee's Social Security #: XXX-XX-______________

Employee Name (Last, First, Middle): ____

Gender: ☐ M ☐ F Marital Status: ☐ Married ☐ Unmarried

Home Address: ____

____

Best contact #: ______________________________

Occupation: ______________________________

Injury Information

Date of injury: ______________________ Time of injury: _______________ ☐ AM ☐ PM

Time employee began work on date of injury: ___________ ☐ AM ☐ PM

Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was: ____

____

Specific description/details of the injury/illness (include the part(s) of body)?

____

What tools, equipment, machines, objects, or substances were involved?

____

Did the injury occur on employer's premises?

Yes, provide building & location: ____

No, provide name and address: ____

Date Supervisor/Employer was notified of injury: ________________________

Extent of medical treatment (check all that apply):

☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital

☐ Emergency room ☐ Hospitalization more than 24 hours

☐ Future major medical anticipated

Treating Facility and Physician (if applicable): ____

OFFICE USE ONLY

Supervisor signature: ___________________________________ Date: ________________________

Received by District Office: ___________________________________ Date: ____________________