FIRST REPORT OF INJURY

Employee: _____

Address: _____

_____

Phone: ( ) _____ Dependents: _____

SSN: _____ DOB: _____

Sex: _____ Marital Status: _____

Occupation: _____ Hire Date: _____

Days Worked Per Week: _____ Hours worked per day: _____

Initial Treatment: _____

ACCIDENT INFORMATION

Accident Date: _____ Accident Time: _____

Date Employer Notified: _____ Last Date Worked: _____

Return to Work Date: _____ Time Employee Began Work: _____

Accident on Premise? _____ Location: _____

Safeguards: _____

Type of Injury: _____

Part of Body Affected: _____ Body Side Affected: _____

All equipment, materials, or chemicals employee was using when the accident occurred:

_____

_____

Specify the activity the employee was engaged in when the accident occurred:

_____

_____

Describe the sequence of events that directly injured the employee:

_____

_____

_____

Witness Name: _____ Phone Number: _____

Hospital/Clinic Information: _____

_____

Employee Signature: _____ Date: _____

COMMENTS: