



# First Report of Injury (FROI) Report Form

PLEASE Email to [FROIinbox@medlogix.com](mailto:FROIinbox@medlogix.com) and copy [aburns@manvillesd.org](mailto:aburns@manvillesd.org)  
**PLEASE ENSURE FORM IS COMPLETED IN ITS ENTIRETY**

<b>Information was reported to:</b>													
NAME AND TITLE:								PHONE NUMBER:					
WILL YOU BE THE CONTACT PERSON? IF NO, WHO WILL BE CONTACT PERSON?		<input type="checkbox"/> YES <input type="checkbox"/> NO		CONTACT PERSON'S NAME:				CONTACT PHONE NUMBER:					
<b>Injury</b>													
DID THE INJURY OCCUR MORE THAN 3 DAYS AGO? (IF YES, WHY THE DELAY IN REPORTING)								<input type="checkbox"/> YES		<input type="checkbox"/> NO			
REASON FOR DELAY:													
<b>Injured Worker Information</b>													
NAME (LAST, FIRST, MIDDLE)						DATE OF BIRTH		SOC. SEC. NUMBER		DATE OF HIRE			
ADDRESS (INCLUDE ZIP)						SEX		MARITAL STATUS					
						MALE		U		SINGLE/DIVORCED UNMARRIED			
						FEMALE		S		SEPARATED			
						UNKNOWN		K		UNKNOWN			
PHONE NUMBER:		12 MO or 10 MO Employee:		# OF DEPENDENTS		EMPLOYMENT STATUS		OCCUPATION/TITLE					
RATE PER	HR	DAYS WORKED/WEEK		HOURS WORKED/DAY		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
<b>Employer</b>													
EMPLOYER NAME: <b>Manville School District</b>													
SCHOOL / LOCATION: ADDRESS:													
PHONE NUMBER: <b>908/231-8500</b>						SUPERVISOR NAME AND TITLE:							
<b>Employee Work Information</b>													
TIME EMPLOYEE BEGAN WORK	AM	PM	WHAT ARE THEIR NORMAL HOURS?				WHAT DATE DID THE EMPLOYEE NOTIFY SOMEONE OF THEIR INJURY?						
TO WHOM WAS IT REPORTED? (NAME & TITLE)			WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	WERE THEY USED?		<input type="checkbox"/> YES	<input type="checkbox"/> NO			
IS THERE A REASON FOR THIS CLAIM TO BE PLACED UNDER INVESTIGATION? (If yes, list reason)													
WAS A STUDENT INVOLVED IN THE INCIDENT? If so, does the student have special needs? Student have a history of violence?													
<b>Occurrence/Injury</b>													
DATE OF INJURY		TIME OF INJURY		AM	PM	DID THE INJURY OCCUR ON THE EMPLOYER'S PREMISE'S?				<input type="checkbox"/> YES	<input type="checkbox"/> NO		
LOCATION/DEPARTMENT WHERE INJURY OCCURRED:													
DESCRIBE HOW INJURY OCCURRED:													
WHAT IS THE NATURE OF THE INJURY AND TO WHAT BODY PART?						Body Part		Left		Upper			
								Right		Lower			
WAS THE INJURY FATAL?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE OF DEATH		DID EMPLOYEE SEEK TREATMENT?		<input type="checkbox"/> YES	<input type="checkbox"/> NO				
WHAT WAS THE MODE OF TRANSPORTATION TO THE PROVIDER?													
HAS THE INJURED WORKER RETURNED TO WORK?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, RETURNED TO WORK DATE		IF NO, LAST DATE WORKED:						
Provider Name Address and Phone No.:						Was Injured Worker hospitalized for more than 24 hours: <input type="checkbox"/> YES <input type="checkbox"/> NO							
ANY LOST TIME FROM WORK DUE TO INJURY?													
<b>Witness</b>													
Witness Name, Phone #, and please attach a brief summary in your own words of what happened:													