

FIRST REPORT OF INJURY - Workers' Compensation

NAME _____ SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

MAILING ADDRESS _____ EMAIL ADDRESS _____

CITY & STATE (INCLUDING ZIP) _____

DEPARTMENT _____ SUPERVISOR _____

NUMBER # OF DEPENDENTS _____	Single <input type="checkbox"/>	MARRIED <input type="checkbox"/>	SEPARATED <input type="checkbox"/>	UNKNOWN <input type="checkbox"/>	SEX M <input type="checkbox"/> or F <input type="checkbox"/>
------------------------------	---------------------------------	----------------------------------	------------------------------------	----------------------------------	--

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DATE OF INJURY/ILLNESS _____ TIME OF OCCURRENCE _____ AM PM TIME EMPLOYEE BEGAN WORK _____ AM PM If disability - list date disability began _____

DATE EMPLOYER NOTIFIED _____ PERSON NOTIFIED _____ PHONE NUMBER _____

PART OF BODY AFFECTED _____ TYPE OF INJURY/ILLNESS (I.E. CUT, BRUISE, BURN, FRACTURE, ETC.) _____

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED, INCL. ZIP _____

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED _____

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES NO WERE THEY USED? YES NO

DESCRIBE THE SEQUENCE OF EVENTS

PHYSICIAN or HEALTH CARE PROVIDER that provided treatment (Name, Address and zip code) HOSPITAL (Name, Address and Zip code)

TREATMENT RECEIVED: NO MEDICAL TREATMENT <input type="checkbox"/>	* MINOR: BY EMPLOYER <input type="checkbox"/>	*MINOR CLINIC/HOSPITAL <input type="checkbox"/>
EMERGENCY CARE <input type="checkbox"/>	*HOSPITALIZED>24 HRS <input type="checkbox"/>	**FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED <input type="checkbox"/>

WITNESSES _____ PHONE NUMBER _____

Special Note: Employees must also complete and sign the Industrial Options form (benefitted employees) and Days Missed form (all employees). Personnel Department: 801-851-8158.