FIRST REPORT OF INJURY - Workers' Compensation

****Please notify Human Resources and your direct supervisor immediately.****

NAME ______ SOCIAL SECURITY NUMBER ______ DATE OF BIRTH ______

MAILING ADDRESS ______ EMAIL ADDRESS ______

CITY & STATE (INCLUDING ZIP) ______

DEPARTMENT______ SUPERVISOR______

NUMBER # OF DEPENDENTS______ SINGLE MARRIED SEPARATED UNKNOWN SEX M or F

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 *MINOR: BY EMPLOYER *MINOR CLINIC/HOSPITAL EMERGENCY CARE *HOSPITALIZED>24 HRS **FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

WITNESSES ______ PHONE NUMBER ______

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

Updated 6/22/2017