Workers' Compensation First Report of Injury

The Supervisor must complete this form along with the employee immediately after the incident	
Name:	Reported to:
Client Address:	Company Phone Number:
Has the employee incurred any lost time from work? Yes No	

1. Injured Worker's Information

Name: ____

First *Last* *Middle Initial*

SSN:	Sex: F M	Date of Birth:
Home Address:		
City:	State:	Zip:
Home Telephone Number:	Cell Phone Number:	
Job Classification:	Date of Hire:	

2. Incident Information

Date of Incident:	Time of Incident: AM / PM	
Time Employer Began Work: ______________ AM / PM	Time Employer Notified: ______________ AM / PM	Date Employer Notified:
Was injury fatal? Yes No	Date of Fatality:	
Was employee in an Emergency Room? Yes No		
Was employee hospitalized overnight as an in-patient? Yes No		
What was the employee doing just before the injury occurred?		
What Happened? Tell us how the injury occurred.		
What was the injury or illness? What object or substance directly harmed the employee?		
Did injury occur on employer premises? Yes No If Yes, please provide location where injury occurred: __________________________		

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Is injured worker seeking medical treatment? If No, please skip to Section 3. Witness Information	Yes	No
Facility Name:		
Facility Address:		
City:	State:	Zip:
Physician Name:		
Physician Number:	Facility Number:	

3. Witness Information

Were there any witnesses to the injury? If No, please skip to Section 4. Supervisor Information	Yes	No
Name (1):		
Client Address (1):	Phone Number (1):	
Name (2):		
Client Address (2):	Phone Number (2):	

4. Supervisor Information

Name:	
Phone Number:	Best Time to Contact:

* * * CLEAR USE ONLY * * *

Date CLEAR Notified:	Report Date:
Insurance:	Claim Number:
Adjuster Name:	
Adjuster Phone Number:	Adjuster Email: