

EMPLOYER'S FIRST REPORT OF INJURY: FIRST NOTICE INFORMATION

EMPLOYER			
INSURED NAME		FEDERAL TAX ID	LOCATION # POLICY #
ADDRESS		UNEMPLOYMENT ID	D/B/A NAME
CITY	STATE	ZIP	ADDRESS
COUNTY	PHONE	SIC/NAICS CODE	CITY STATE ZIP
EMPLOYEE			
FIRST NAME	MIDDLE NAME	LAST NAME	EMPLOYEE NUMBER SSN PHONE NO.
ADDRESS		DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE MARITAL STATUS # DEPENDENTS
CITY	STATE	ZIP	OFFICER / PARTNER DATE OF HIRE STATE OF HIRE MINOR'S WORK CERTIFICATE NUMBER (IF UNDER 18)
COUNTY			<input type="checkbox"/> YES <input type="checkbox"/> NO
REGULAR DEPARTMENT OR DIVISION No. NAME	OCCUPATION		NCCI CLASS CODE
WAGE RATE	PER	AVERAGE HOURS/DAY	AVERAGE DAYS/WEEK
OCCURRENCE			
PLACE OF ACCIDENT OR OCCURRENCE		DATE OF INJURY / ILLNESS	DID EMPLOYEE LOSE ONE OR MORE DAYS OF WORK?
CITY	STATE	ZIP	<input type="checkbox"/> YES
COUNTY OF INJURY	FILING STATE	TIME OF OCCURRENCE	LAST DATE WORKED
EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		TIME WORKDAY BEGAN	FIRST DATE OF DISABILITY
			FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
			DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
RETURNED <input type="checkbox"/> YES: DATE		DATE EMPLOYER NOTIFIED PERSON NOTIFIED	
TO WORK? <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			
DESCRIBE NATURE OF INJURY OR ILLNESS IN DETAIL (Include part of body affected, e.g., strain to lower back, fractured arm, lead poisoning.)			
EMPLOYEE'S WORK ACTIVITY AT TIME OF INJURY (e.g., loading truck, typing, assembling product)			
DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURRED WITH DETAILS OF HOW EVENT OCCURRED (Who was involved, tools, machinery, employee's actions, etc.)			
FATALITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
DATE OF DEATH			
MEDICAL INFORMATION			
SELECT TYPE OF TREATMENT	<input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> HOSPITALIZED <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> EMERGENCY ROOM <input type="checkbox"/> IN-HOUSE / FIRST AID <input type="checkbox"/> UNKNOWN	FACILITY NAME ADDRESS CITY	TELEPHONE PHYSICIAN'S NAME
WITNESSES (NAME & PHONE NO.)		STATE	ZIP
DATE COMPLETED	REPORTED BY	TITLE	PHONE NUMBER AND EXT.