

**Lackawanna Insurance Group
Workers' Compensation
First Report of Injury Form**

Page 1 of 2

(* denotes required field)

*Date of Injury:

*Employee Social Security No:

*Employee First Name:

*Employee Last Name:

*Street Address:

*City:

*State:

*Zip Code:

County:

*Phone No:

*Date of Birth:

*Gender:

Marital Status:

No. of Dependents:

*Occupation or Job Title:

*Employment Status:

*Date of Hire:

*Employer:

*Employer Contact First Name:

*Employer Contact Last Name:

*Employer Contact Phone No:

Employer Contact Fax No:

Employer Contact E-Mail Address:

*Street Address:

*City:

*State:

*Zip Code:

County:

*Phone No:

Employer FEIN.:

Policy Number:

Policy Period Dates:

*Date & Time Employer Notified:

*Time employee began work:

*Time of occurrence:

*Full pay for day of injury?:

Last day worked:

Date of disability:

Date returned to work:

*Type of Injury:

*Part of Body Affected:

*Cause of Injury:

*How injury/illness/abnormal health condition occurred. Describe sequence of events including objects/substances directly responsible:

*Did injury or illness occur on employer's premises?:

*If accident did not occur at Employer Address provided on page one (1), please provide complete address:

*If Injury Out of State, Specify State:

*Were safeguards or safety equipment provided?:

*Were safeguards or safety equipment used?:

All equipment, material, or chemicals employee was using when accident or illness exposure started:

If fatal, give date of death:

- Type of Initial Treatment:
- No (formal) Medical Treatment; only first aid
 - Hospital – Emergency Care
 - Panel Physician
 - Employee Physician

Healthcare Provider Name:

Street Address:

City:

State:

Zip Code:

Phone No:

Witness First Name:

Witness Last Name:

Witness Phone No.:

*Person Completing This Form – Name:

*Phone Number: