

First Report of Injury Form  
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(\* DENOTES REQUIRED FIELDS)

**Employee Social Security No:**  
\*  
\_\_\_\_\_  
**Date of Injury:**  
\*  
\_\_\_\_\_

**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 Name:**  
\*  
\_\_\_\_\_

**Employer Contact Phone No:** \_\_\_\_\_ **Employer Contact Fax No:** \_\_\_\_\_  
\* \_\_\_\_\_

**Employer Contact E-Mail Address:**  
\*  
\_\_\_\_\_

**Street Address:**  
\*  
\_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
\* \* \*

**County:** \_\_\_\_\_ **Phone No:** \_\_\_\_\_  
\* \_\_\_\_\_

**Employer Federal ID No.:** \_\_\_\_\_ **Policy No.:** \_\_\_\_\_ **Policy Period Dates:** \_\_\_\_\_  
\_\_\_\_\_

**Did injury or illness occur on employer's premises?:** \_\_\_\_\_ **State of Injury:** \_\_\_\_\_  
\* \*

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Address where injury occurred if different than Employer's address listed above  
Street Address:  
\*

City: State: Zip Code:  
\* \* \*

Date 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 (if applicable):  
\* \* \* \*

Type of Injury: Part of Body Affected: Cause of Injury:  
\* \* \*

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:

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

If fatal, give date of death:  
\*

Hospital /Healthcare Provider Name  
  
Street Address:  
City: State: Zip Code

Check	Initial Treatment
	No Medical Treatment/ Minor by Employee
	Healthcare Provider
	Panel Physician
	Employee Physician

Phone No:

Witness Name:

Witness Phone No.:

Name of Person Completing This Form:  
\*

Title:  
\*

Phone No:  
\*

Fax No:  
\*