Lackawanna Insurance Group
Workers' Compensation
First Report of Injury Form

(* 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: