Lackawanna Insurance Group

Lackawanna Casualty Company, Lackawanna American Insurance Company, Lackawanna National Insurance Company

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(570) 824-1400
(888) 280-5225 (570)
824-7969 (fax)
www.ligins.com

Workers Compensation First Report of Injury (FROI)

Please complete **at least** the shaded fields

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY (Month Date Year)

TIME OF INJURY

STATE OF INJURY

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

GENDER

DATE OF BIRTH (Month Date Year)

MARITAL STATUS

OCCUPATION OR JOB TITLE

DATE OF HIRE (Month Date Year)

EMPLOYMENT STATUS

FT=Full-time
PT = Part-Time
SLFT = Seasonal Full-time
SLPT = Seasonal Part-time
VO = Volunteer
OTH: Other

EMPLOYER

STREET ADDRESS

CITY

STATE

ZIP CODE

EMPLOYER FEDERAL ID NO:

POLICY NUMBER

POLICY PERIOD

EMPLOYER CONTACT NAME

PHONE NUMBER

FAX NUMBER

E-MAIL ADDRESS

DID INJURY/ILLNESS OCCUR AT ABOVE LISTED EMPLOYER'S ADDRESS? IF NO, COMPLETE ADDRESS WHERE INJURY/ILLNESS OCCURRED,

DATE EMPLOYER NOTIFIED

Month Date Year

TIME EMPLOYEE BEGAN WORK

FULL PAY FOR DAYOF INJURY?

IS EMPLOYEE OUT OF WORK DUE TO INJURY?

LAST DAY WORKED

Month Date Year

DATE DISABILITY BEGAN (1st Day Out of Work)

Month Date Year

DATE RETURNED TO WORK

Month Date Year

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?

WERE SAFEGUARDS OR SAFETYEQUIPMENT USED?

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY/ ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE

IF FATAL, GIVE DATE OF DEATH

Month Date Year

WITNESS NAME

WITNESS PHONE NO

TREATMENT:

	NO MEDICAL TREATMENT SOUGHT
	PANEL PROVIDER
	EMPLOYEE PHYSICIAN
	EMEGENCY - HOSPITAL
	HOSPITILIZATION – MORE THAN 24 HOURS

HEALTHCARE PROVIDER NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

FAX NUMBER

INITIAL TREATMENT DATE

Month Date Year

NAME OF PERSON COMPLETING FORM

PHONE NUMBER