First Report of Injury

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? ☐ Yes ☐ No
Employer's name		Doing business as	
Employer's mailing address			
Nature of business or service		SIC code	
Name of workers' compensation carrier/admin.	Policy/Contract #		Self-insured? ☐ Yes ☐ No
Employee's full name		Social Security #	Birthdate
Employee's mailing address			Employee's e-mail address

☐ Male ☐ Female	☐ Married ☐ Single	# Dependents	Employee's average weekly wage
Job title	Department		Date hired
Time employee began work AM ☐ PM ☐	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? ☐ Yes ☐ No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? ☐ Yes ☐ No		Was the employee hospitalized overnight as an inpatient? ☐ Yes ☐ No	
Report prepared by	Signature		Title and telephone #