First Report of Injury

NAME: _____
FIRST MI LAST

SSN: _____ DATE OF BIRTH: _____

DATE OF INJURY:_____ TIME OF INJURY _____

DATE EMPLOYER NOTIFIED:_____

HAS EMPLOYEE MISSED WORK (OTHER THAN DAY OF ACCIDENT)? _____YES _____NO

EMPLOYEE ADDRESS: _____

CITY_____ STATE_____ ZIP _____

PHONE NUMBER: _____

GENDER: _____ MALE _____ FEMALE MARITAL STATUS: _____

DATE OF HIRE: _____ JOB TITLE: _____

DEPT:_____ SUPERVISOR: _____

OF DAYS WORKED/WEEK _____ # OF HOURS WORKED/WEEK _____

BODY PART AFFECTED: _____

DESCRIPTION OF ACCIDENT: _____

_____

DESCRIBE INJURY OR ILLNESS: _____

_____

WAS MEDICAL TREATMENT PROVIDED?_____

If yes, what type: _____ Clinic _____ Physician _____Hospital

Name of facility or physician: _____

Please submit to:
Roger Olson
Risk Management
Phone: 299.3682
FAX: 299.4945