

# STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY

Approved by I.A.I.A.B.C.

State's Number For:	File: _____ Carrier: _____ Employer: _____
Carrier's File No. _____	
(The spaces above not to be filled in by Employer)	

Employer	1. Name of Employer _____
	2. Office Address: No. and St. _____ City or Town _____ State _____
	3. (a) Are you insured to provide payment to injured employees under the Workmen's Compensation Act _____ (b) If so insured, give name of insurance company (not name of agent) _____
	4. Give nature of business (or article manufactured) _____

Time and Place	5. (a) Location of plant or place where accident occurred _____ Department _____ State if employer's premises _____ (b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill _____
	6. Date of Injury _____ 19 ____ Day of week _____ Hour of day _____ A.M. _____ P.M.
	7. Date disability began _____ 19 ____ A.M. _____ P.M. 8. Was injured paid in full for this day _____
	9. When did you or foreman first know of injury _____
	10. Name of foreman _____

Injured Person	11. Name of Injured _____ (Social Sec. No.) _____ (First Name) (Middle Initial) (Last Name)
	12. Address: No. and St. _____ City or Town _____ State _____
	13. Check (✓) Married _____, Single _____, Widowed _____, Widower _____, Divorced _____; Male _____, Female _____
	14. Speak English _____
	15. Age _____ Did you have on file employment certificate or permit _____
	16. (a) Occupation when injured _____ (b) Was this his or her regular occupation _____ (If not, state in what department or branch of work regularly employed) _____
	17. (a) How long employed by you _____ (b) Piece or time worker _____ (c) Wages per hour \$ _____
	18. (a) No. hours worked per day _____ (b) Wages per day \$ _____ (c) No. days worked per week _____ (d) Average weekly earnings \$ _____ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month _____

Cause of Injury	19. Machine, tool or thing causing injury _____ 20. Kind of power (hand, foot, electrical, steam, etc.) _____
	21. Part of machine on which accident occurred _____
	22. (a) Was safety appliance or regulation provided _____ (b) Was it in use at time _____
	23. Was accident caused by injured's failure to use or observe safety appliance or regulation _____
	24. Describe fully how accident occurred, and state what employee was doing when injured _____ _____ _____
25. Names and addresses of witnesses _____ _____	

Nature of Injury	26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left) _____
	27. Probable length of disability _____ 28. Has injured returned to work _____ If so, date and hour _____ at what wage \$ _____ At what occupation _____
	29. Did you provide medical attention _____
	30. (a) Name and address of physician _____ (b) Name and address of hospital _____

Fatal Cases	31. Has injured died _____ If so, give date of death _____
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Date of this report \_\_\_\_\_ Firm Name \_\_\_\_\_  
Signed by \_\_\_\_\_ Official Title \_\_\_\_\_