



First Report Of Injury or Illness

First name of injured person:

Last name:

SSN:

DOB:

Instructions: This form is for the collection and reporting of data associated with a work-related, injury, illness or incident. Clients must complete this entire form and submit either by email (preferred method) or signed paper copy to National HR **within 24 hours of receiving notice of the injury, illness or incident.** It is National HR Solution's expectation that the following protocols be met in the event of injury or illness:

- 1) Injury, Illness or any relevant Incident will be immediately reported to National HR by submission of this form and any supporting documents
- 2) Medical care, when appropriate, will be authorized and client will assure a designated medical facility is utilized (where allowed by statute)
- 3) Client will comply with post-accident requirements (substance abuse screening, investigations, return-to-work efforts and status updates etc.)

Incident Details

1. Date of incident: <small>(MM/DD/YY)</small>	2. Time of incident: <input type="checkbox"/> am <input type="checkbox"/> pm	3. Date reported: <small>(MM/DD/YY)</small>	4. Time reported: <input type="checkbox"/> am <input type="checkbox"/> pm	5. Incident type: <input type="checkbox"/> Report Only <input type="checkbox"/> Injury - no lost time <input type="checkbox"/> Injury - lost time <input type="checkbox"/> Injury - med only
6. Description of incident: (limited to 250 characters, be sure to include detail about the body part, cause, and nature of injury) <i>For example: "worker developed soreness in left wrist over time doing computer work" or "slipped and fell on wet floor breaking right leg"</i>				7. Chemical, tools, equipment, or items involved: (e.g. "boxes")
				8. Specific body part:
9. Client:		10. Address		11. Exact location of incident:
12. Incident reported to (full name):			13. Work phone: ()	14. Has incident investigation been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Person reporting incident (full name):			16. Work phone: ()	17. Incident result in fatality? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter date:
18. Is there a witness to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	19. Witness's full name (if more than one please attach separate page):			20. Witness's phone: ()
21. Did incident involve travel? <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Was a 3rd Party Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		23. Police Report Available? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee Details

24. Injured person's employment status <input type="checkbox"/> Employee <input type="checkbox"/> Contract Worker				
25. First name of injured person:	26. Middle initial:	27. Last name:		
28. Address:		29. Work phone: ()	30. Home phone: ()	34. Start time day of injury: ■
31. Work shift (e.g. M-F 8:00am-4:30pm):	32. Does employee have second job? <input type="checkbox"/> Yes <input type="checkbox"/> No	33. Second employer name:		
34. Has injured employee missed work due to injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	35. First date missed work	36. Date last at work	37. Employee Date of Hire	
38. Date employer notified of lost time:	39. Employee return to work date		40. :Employee Marital Status	
41. Was medical treatment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	42. Emergency room visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	43. Employee Occupation at time of incident		
44. Medical facility's name and address: <i>(if no medical treatment please respond "None")</i>				
45. Treating physician's name: <i>(if no medical treatment please respond "None")</i>		46. Physician's phone		

Investigative Detail

47. Supervisor/Designee name:	48. Work phone:	49. Date:
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<p>Forward this form as an email attachment immediately to National HR Solutions</p> <p>Email: claims@nationalhrsolutionsinc.com</p> <p>Phone: 888-664-0934</p> <p>Date Received</p>	<p>50. Check if "Yes" Comments:</p> <p>Is the validity of this claim in question?</p> <p>Is this a repeat injury?</p> <p>Did employee continue work after injury?</p> <p>Could this injury have been prevented?</p> <p>Any violation of safety protocols?</p>
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