Employer's First Report of Work-Related Injury Worksheet

Per Section 110 of the Workers' Compensation Law a work-related injury or illness must be reported within 10 days of notice of the injury or be subject to a penalty. If you need assistance completing this form **please contact: the Injury Management Department at The Flanders Group at (866) 334 -7222.**

WCB Case # (if known) ____________ Date of Injury ____________ mm/dd/yyyy

Carrier Case # (if known) ____________ OSHA Case # (if applicable) ____________

Policyholder Details

Employers Name ____________

Policy Mailing Address ____________

City ____________ State ______ Zip Code ______

Entity Name ____________

Entity Location ____________

City ____________ State ______ Zip Code ______

FEIN ____________ Policy # ____________ Policy Effective Date ____________ mm/dd/yyyy

Have you given the employee a Claimant Information Packet? ☐ Yes ☐ No If yes, date given ____________ mm/dd/yyyy

Employee Information

First Name ____________ Middle Name / Initial ____________

Last Name ____________ Suffix ______ Phone Number ______ - ______ - ______

Date of Birth: ____________ mm/dd/yyyy ☐ Male ☐ Female SSN or Immigration ID# ____________

Is English their primary language? ☐ Yes ☐ No If no, what is their primary language? ____________

Mailing Address ____________ Apt # ______

City ____________ State ______ Zip Code ______

Physical Address (if different) ____________

Time of day employee began work on date of injury ______ : ______ ☐ AM ☐ PM Time of Injury ______ : ______ ☐ AM ☐ PM

Has employee given you notice of injury/illness? ☐ Yes ☐ No If Yes, ☐ Verbally ☐ In Writing ☐ Both

Date notice given ____________ mm/dd/yyyy Who was notice given to? ____________

When was your last contact with the employee? ____________ mm/dd/yyyy

Who spoke with employee? ____________

Accident Description

Where did the injury/illness happen? (include city, state, zip) ______________________________

____

Is the accident location the same as the policy location? ☐ Yes ☐ No

If no, accident site organization name ______________________________

Was this location where the employee normally worked? ☐ Yes ☐ No

If no, why was the employee there? ______________________________

Employee Supervisor Name ____________________ Did Supervisor witness the incident? ☐ Yes ☐ No

Did anyone else see the injury happen? ☐ Yes ☐ No If yes, provide witness information below

Witness Name	Witness Phone Number

What was the employee doing when injured? ______________________________

____

____

How did the injury/illness occur? (What caused the injury?) ______________________________

____

____

What body part(s) were injured? (i.e. left arm, right foot, head, etc.) ______________________________

Nature of injury (i.e. laceration, burns, fracture, strain, etc.) ______________________________

To your knowledge, did the Employee have another work-related injury to the same body part or similar illness while working for you? ☐ Yes ☐ No If yes, please explain ______________________________

Death as a result of injury? ☐ Yes ☐ No If yes, date of death ____________ (mm/dd/yyyy) Number of Dependents ________

Was an object involved? (hammer, ice, etc.) ☐ Yes ☐ No If yes, what object ______________________________

Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No

If yes, ☐ Employee's vehicle ☐ Employer's vehicle ☐ Other Vehicle

Motor Vehicle License Plate Number (if known) ______________________________

Motor Vehicle Insurance Carrier (if known) ____________________ Ins Policy # (if known) ________

Medical Treatment Information

Did the employee receive treatment for this injury/illness? ☐ Yes ☐ No If yes, date of first treatment ____________ (mm/dd/yyyy)

Where did the employee receive their first medical treatment for injury/illness?

☐ No Medical Treatment ☐ Minor On-Site Treatment by Employer ☐ Minor Clinic/Hospital Treatment

☐ Emergency Evaluation ☐ Hospitalization Greater than 24 hours ☐ Future Treatment Anticipated

Who treated the employee? (if known) ______________________________

Location of facility/office ______________________________

Is the employee still being treated for this injury/illness? ☐ Yes ☐ No ☐ Unknown

If yes, please provide the name and address of treating medical provider (include city, state, zip) ______________________________

____

Work Information

Did the employee stop work because of his/her injury/illness? ☐ Yes ☐ No If yes, on what date? ____________
mm/dd/yyyy

Did employee lose more than or is anticipated to lose more than one week of work? ☐ Yes ☐ No

Has the employee returned to work? ☐ Yes ☐ No If yes, on what date? ____________
mm/dd/yyyy

If yes, in what capacity? ☐ Full ☐ Modified If modified, describe the physical restrictions ____________

Is modified duty available? ☐ Yes ☐ No

Have you received any medical info or out of work notes? ☐ Yes ☐ No

If he/she returned to modified duty, is there any reduction in earnings? ☐ Yes ☐ No If yes, $ ________

Date employee was hired ____________ Employee's gross pay in an average week $ ____________
mm/dd/yyyy

Job Title ____________ Job Duties ____________

Did employee receive lodging or tips in addition to pay? ☐ Yes ☐ No

If yes, describe (include monthly value of lodging if applicable) ____________

Employment status (full time, part time, seasonal) ____________

Days usually worked ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sat ☐ Sun # of days worked per week ________

Was the employee paid for a full day on the day of injury/illness? ☐ Yes ☐ No Last day paid ________
mm/dd/yyyy

Did you continue to pay salary in lieu of compensation (e.g. sick leave, vacation)? ☐ Yes ☐ No

Is there any reason to investigate this claim as reported? ☐ Yes ☐ No If yes, explain ____________

Are there any employment issues prior to this claim (absenteeism, disciplinary issues, etc)? ☐ Yes ☐ No
if yes, explain ____________

Any additional information that may be pertinent to the case ____________

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT

The abiove information is true to the best of my knowledge and belief

Signature of person preparing form ____________ Date ________
mm/dd/yyyy

Print Name ____________ Title ____________ Phone # ________