FIRST REPORT OF INJURY

**If your injury requires immediate attention, or is life threatening, please report to the nearest emergency room.**

**For prompt handling of your claim, please ensure all fields are completed to the best of your ability:**

|  |  |  |  |
| --- | --- | --- | --- |
| Injury Date:  |  | Person Reporting Claim: |  |
| Injury Time: |  | Phone# of Person Reporting Claim: |  |

Employee Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Claimant SSN:** |  |  **Date of Birth:** |  |  **Age:** |  |
| **Legal Name:** |  |  **Marital Status:** |  |  **Gender:** |  |
| **Address:** |  |  **Days Worked:** |  |  **Employment Status:** |  |
|  **Wage Rate (Monthly)**  |  |
| **Home Phone:** |  |  **10 or 12 Month Employee:** |  |  **Work Hours:** |  |
| **Cell Phone:** |  |  **Title:** |  |  **Personal Email:** |  |
| **Employer Information** |
| **Employer:** |  | **Phone:** |
| **Location of Accident:** |  | **Contact:** |
| **Location of Accident Off Premises:**  |  |
| **Location Address:****City, State & Zip** |  |

Incident Information

|  |  |  |
| --- | --- | --- |
| **Date employer notified:** |  | **Injury reported to:**  |
| **Who incident was reported to:** |  |
| **Supervisor name:** |  |
| **Witness name & phone:** |  |
| **Nature of injury:** |  |
| **Part of body affected:** |  |
| **Object causing injury:** |  |
| **How injury occurred:** |  |
| **Dominant hand:** |  |
| **Prior medical condition? (Please describe all conditions)** |  |
| **Previous workers’ comp injury?****(Please provide dates/injuries)** |  |
| **Primary Care Physician:** |  |
| **Mitchell card received?** |  [ ]  Yes [ ]  No  |
| **NJSIG/QualCare Card Received?** |  [ ]  Yes [ ]  No  |
|  **Child involved & age**  |  [ ]  Yes [ ]  No Age:  |
| **Special needs child:** |  [ ]  Yes [ ]  No  |

Initial Treatment

|  |  |
| --- | --- |
| Is treatment being requested? |  [ ]  Yes [ ]  No If treatment is being requested, an NJSIG representative will reach out to you on the next business day. |

|  |  |
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| Additional Comments: |  |