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

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| --- | --- | --- |
| **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

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| --- | --- |
| 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: |  |