EMPLOYER'S FIRST REPORT OF WORK-RELATED INJURY / ILLNESS

GNP INSURANCE BROKERAGE

EMPLOYEE PERSONAL INFORMATION

FIRST NAME

LAST NAME

MAILING ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

DATE OF HIRE

DATE OF BIRTH

GENDER

☐ Male ☐ Female ☐ Unknown

SOCIAL SECURITY NUMBER

OCCUPATION

PREFERRED LANGUAGE

EMPLOYEE CLAIM INFORMATION

DATE OF INJURY

TIME OF INJURY

☐ am ☐ pm

WHAT TIME DID THE EMPLOYEE START WORK ON THE DAY OF INJURY?

☐ am ☐ pm

WHAT DATE DID THE EMPLOYEE REPORT THE INJURY?

ESTIMATED WEEKLY WAGE

NUMBER OF DAYS WORKED PER WEEK

Work Week Type: ☐ Standard work week ☐ Fixed work week ☐ Varied work week

Work Days Scheduled: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Employee Work Type: ☐ Full Time ☐ Part Time ☐ Per Diem

Injured Worker Status: ☐ Employee ☐ Subcontractor / Agency Staff

EMPLOYEE INJURY

Was the employee paid in full on the date of the injury? ☐ Yes ☐ No

Is the employee still being paid by the employer? ☐ Yes ☐ No

Where did the employee go for initial medical treatment?

☐ No medical treatment

☐ Minor on-site treatment by the employer, minor clinic / hospital treatment

☐ Hospitalization greater than 24 hours

INJURY DETAILS

NAME OF THE FACILITY THE EMPLOYEE WENT TO FOR MEDICAL TREATMENT

Did the injury result in death? ☐ Yes ☐ No

NATURE OF INJURY (STRAIN, SPRAIN, FRACTURE, CONTUSION, LACERATION, ETC.)

BODY PART INJURED (LEFT ARM, HEAD, RIGHT FOOT, BACK, ETC.)

CAUSE OF INJURY (MOTOR VEHICLE ACCIDENT, LIFTING, SLIP/TRIP, FALL, ETC.)

ACCIDENT / INJURY DESCRIPTION

EMPLOYEE WORK STATUS

Is the employee losing time from work due to their injury? ☐ Yes ☐ No

DATE THE EMPLOYEE LAST WORKED

Has the employee been released to return to work? ☐ No ☐ Full Duty ☐ With Restrictions

DATE THE EMPLOYEE RETURNED TO WORK

ACCIDENT LOCATION & WITNESSES

Facility location the employee reports to

STREET | CITY | STATE | ZIP CODE

Location of the accident

STREET | CITY | STATE | ZIP CODE

Witnesses

NAME | PHONE NUMBER

NAME | PHONE NUMBER

NAME | PHONE NUMBER

REPORTING INFORMATION

NAME OF PERSON SUBMITTING THIS REPORT | PHONE NUMBER

EMAIL OF PERSON SUBMITTING THIS REPORT

ADDITIONAL COMMENTS

ANY RED FLAGS OR KNOWN PRIOR INJURIES?