PART 1: EMPLOYER'S FIRST REPORT OF INJURY

Employer:		Policy Number:
Address:		
Phone Number:		Facsimile Number:
Employer Contact:		Employer Contact Phone Number and email:
Employee's Name:		
Social Security Number:	Date of Birth:	Sex: Male ☐ Female ☐
Race/Ethnic Identification (per/for DWC-7) White ☐ African-American ☐ Hispanic ☐ Asian ☐ Other ☐		
Employee's Address:		
City:	State & Zip:	Home Phone:
Job Title:	Date of Hire:	Department:
Date of Injury:	Date Reported by Employee:	
Location of Injury (check one): Primary Business location ☐ Off site location ☐ during travel ☐		
Description of Accident:		
Losing time from work? Yes ☐ or No ☐		Date lost time began:
Time Employee began work:		
Time of Injury: A.M.☐ or P.M. ☐		Rate of Pay $ Hourly ☐ or Salary ☐
Avg # of Hours Worked per Week:		Speaks English: Yes ☐ or No ☐ Preferred Language:
Medical Attention provided away from worksite required: (if so, name of Physician or Medical Facility and phone number:		
Was the Employee treated in an Emergency Room? Yes ☐ or No ☐ Was Employee hospitalized overnight as an In-Patient? Yes ☐ or No ☐		
Signed/Completed by:	Position/Title:	Date:

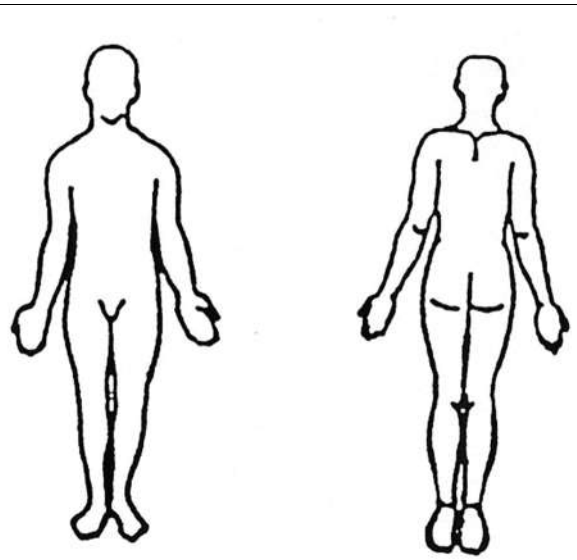
PART 2: EMPLOYEE STATEMENT AND INFORMATION

(TO BE COMPLETED BY THE EMPLOYEE)

Employee's Name:	
Date of Birth:	Social Security Number:
Street Address:	
State & Zip:	Home Phone:
Email Address:	Job Position/Title:
Date of Hire:	Department:
Direct Supervisor:	Normal Work Schedule (Days of the Week):
Average Hours Worked Per Week:	Rate of Pay:
ACCIDENT DETAILS	
How were you injured?	
What job were you performing at the time of the accident?	
List the exact Injuries you sustained and to what part of your body. List **all** injuries.	
Who did you report this injury to?	When did you report it (Date and Time):
Were there any witnesses to this event? If so, please list their names.	

Form continues on following page

PART 2: EMPLOYEE STATEMENT AND INFORMATION (CONTINUED)

<table>
<tr><td>On the diagram to the right, please circle the parts of your body where you are experiencing pain due to this injury.</td><td colspan="2">  </td></tr>
<tr><td>Print Name:</td><td>Signature:</td><td>Date:</td></tr>
<tr><td colspan="3">I certify that by executing and signing this document that this is a true and accurate report of the circumstances which occurred on the date of my injury/accident listed above.</td></tr>
</table>

PART 3: SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Employee's Name:	Social Security Number:	Date of Birth:
Employee's Job Position/Title:	Date of Hire:	
Employee's Direct Supervisor:		
Date of Accident:	Time of Accident:	On Insured's premises: Yes ☐ or No ☐
To Whom did the Employee report the Accident to?		
When was the Accident Reported? (Include Date and Time):		
Actual location of accident (physical location on Insured's premises or address if accident off site):		
List any/all witnesses to accident:		
Name:	Address:	Phone:
Name:	Address:	Phone:
Name:	Address:	Phone:
Was Employee taken for Medical Care? Yes ☐ or No ☐	Taken by: Employer ☐ or On his own ☐	
Did the Employee lose time from work? Yes ☐ or No ☐	Date Returned to Work:	
Describe the Accident Details as they were first reported to you:		
Name of Medical Provider (include Address/Phone if possible):		
Signed/Completed by:	Position/Title:	Date:

PART 4: WITNESS STATEMENT

Name of Witness:	Date of Incident:
Name of Injured employee:	
Address:	Telephone Number:
Same Employer as injured employee? Yes ☐ or No ☐	
If not, employed by:	Employer's telephone number:
Are you related to the injured employee? Yes ☐ or No ☐	If "YES", how?
Please state the date and time of the injury:	
Did you actually see this injury happen? Yes ☐ or No ☐ If "NO", how do you know about it?	
How near to the injured employee were you at the time of the injury?	
Please explain in detail what you know about this incident:	
Did this employee ever talk with you about getting hurt on the job? Yes ☐ or No ☐ If "YES", what was the date and time this conversation took place? What did the employee say?	
Do you know of any other injury, accident, or illness this employee has had? Yes ☐ or No ☐ If "YES", please explain:	
Give the names of any other persons who might know about this accident/ injury:	
Additional comments:	
To the best of my knowledge, this statement is true and correct.	
Signature of Witness:	Date Signed: