



**EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS**

1. Name (Last, First, M.I.):		2. UIN:		3. Date of Birth:	
4. Home Phone:			5. Mailing Address:		
6. Date of Injury:		7. Time of Injury:		8. Date Lost Time Began:	
		: AM PM		: AM PM	
9. Nature of Injury:			9. Nature of Injury:		
10. Was Employee doing his/her Regular Job?			11. Part of Body Injured or Exposed:		
12. Worksite Location of Injury (stairs, office, clinic, etc.):			13. Address Where Injury or Exposure Occurred (if not at SHS):		
14. How and Why Injury/Illness Occurred:					
15. Cause of Injury/Illness (fall, tool, machine, etc.):					
16. List Witnesses:					
17. Return to work date/or expected date:			18. Date Injury Reported:		
19. PRINT Name and Title of Person Completing Form:			20. SIGNATURE of Person Completing Form:		
			_____		
			Date		