First Report of Injury or Illness

Employer: **Location:**

Instructions

This form is for the collection and reporting of data associated with a work-related, injury, illness or incident. Clients must complete this entire form and submit either by email (preferred method) or signed paper copy to Infiniti HR within 24 hours of receiving notice of the injury, illness or incident. It is Infiniti HR's expectation that the following protocols be met in the event of injury or illness:

1) Injury, Illness or any relevant Incident will be immediately reported to Infiniti HR by submission of this form and any supporting documents
2) Medical care, when appropriate, will be authorized and client will assure a designated medical facility is utilized (where allowed by statute)
3) Client will comply with post-accident requirements (substance abuse screening, investigations, return-to-work efforts and status updates etc.)

Employee Details

Social Security Number:	First name:	Last name:		
Home Address:	City:	State:	Zip Code:	
Home Phone: ( )	Cell Phone: ( )	Email:	Preferred Language:	Date of Birth:

Incident Details

Date of Incident:	Time of Incident: AM ☐ PM ☐	Date Reported:	Incident Type: Medical ☐ Report Only ☐ Lost Time ☐

Description of Incident: (limited to 250 characters, be sure to include detail about the body part, cause, and nature of injury) *For example: "worker developed soreness in left wrist over time doing computer work"*

Location of Incident:	Has incident investigation been completed? Yes ☐ No ☐	
Incident reported to (full name):	Work Phone: ( ) Email:	Employee's Supervisor? Yes ☐ No ☐

Witness's Full Name:	Witness's Phone: ( )	Third Party involved? *(if yes, please provide their contact and insurance information on a separate sheet)* Yes ☐ No ☐	Police Report Available? Yes ☐ No ☐

Employment Details

Employee's Work Status: (check all that apply) Full Time ☐ Part Time ☐ Temporary ☐ Contract Worker ☐	Work shift *(e.g. M-F 8:00am-4:30pm)*:		
Address of Employment:	City:	State:	Zip:

Date of Hire:	First date of missed work:	Last date at work:	Job Title: Class Code:

Medical Treatment

Medical Facility's Name:	Medical Facility's Address:	
Treating Physician's Name:	Treating Physician's Phone: ( )	Treating Facility's Phone Number: ( )

Employer Contact

Designee Name:	Work Phone: ( )	Date:

Forward this form as an email attachment or by fax immediately to Infiniti HR:

Email: claims@infinitihr.com
Fax: 410-630-5474
Phone: 301-841-6380

Check if Yes	
Is the validity of this claim in question?	☐
Is this a repeat injury?	☐
Did employee continue work after injury?	☐
Could this injury have been prevented?	☐
Any violation of safety protocols?	☐

Comments: