First Report Of Injury or Illness

First name of injured person:
Last name:
SSN: DOB:

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) Clent will comply with post-accident requirements (substance abuse screening, investigations, return-to-work efforts and status updates etc.)

Incident Details

1. Date of incident: (MM/DD/YY)	2. Time of incident: ☐ am ☐ pm	3. Date reported: (MM/DD/YY)	4. Time reported: ☐ am ☐ pm	5. Incident type: ☐ Report Only ☐ Injury – no lost time ☐ Injury - lost time ☐ Injury - med only

6. 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" or "slipped and fell on wet floor breaking right leg"*	7. Chemical, tools, equipment, or items involved: (e.g. "boxes")
	8. Specific body part:

9. Client:	10. Address	11. Exact location of incident:

12. Incident reported to (full name):	13. Work phone: ( )	14. Has incident investigation been completed? ☐Yes ☐No
15. Person reporting incident (full name):	16. Work phone: ( )	17. Incident result in fatality? ☐Yes ☐No If yes, enter date:

18. Is there a witness to the incident? ☐Yes ☐No	19. Witness's full name (if more than one please attach separate page):	20. Witness's phone: ( )

21. Did incident involve travel? ☐Yes ☐No	22. Was a 3rd Party Involved? ☐Yes ☐No	23. Police Report Available? ☐Yes ☐No

Employee Details

24. Injured person's employment status ☐Employee ☐Contract Worker

25. First name of injured person:	26. Middle initial:	27: Last name:

28. Address:	29. Work phone: ( )	30. Home phone: ( )	34. Start time day of injury:

31. Work shift *(e.g. M-F 8:00am-4:30pm):*	32. Does employee have second job? ☐Yes ☐No	33. Second employer name:

34. Has injured employee missed work due to injury? ☐Yes ☐No	35. First date missed work	36. Date last at work	37. Employee Date of Hire
38. Date employer notified of lost time:	39.Employee return to work date		40. :Employee Marital Status
41. Was medical treatment provided? ☐Yes ☐No	42 Emergency room visit? ☐Yes ☐No		43. Employee Occupation at time of incident

44. Medical facility's name and address:

(if no medical treatment please respond "None")

45. Treating physician's name: *(if no medical treatment please respond "None")*	46. Physician's phone

Investigative Detail

47. Supervisor/Designee name:	48. Work phone:	49. Date:

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

Email: claims@infinitihr.com
Phone: 301-329-6472

Date Received

50. Check if "Yes" Comments:

- ☐ 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?