FIRST REPORT OF INJURY OR ILLNESS
PRELIMINARY REPORT

Employee Name: _______________________ **SSN:** ____ /____/_____ **BANNER ID:@**______________

Home Phone# (_____)______-_______ **Cell#**(_____)______-_______ **Wk#** (_____)______-_______

Home Address____
Mailing Address **City** **State** **ZIP**

Marital Status: M ( ) S ( ) D ( ) W ( ) Date of Birth: ____/____/____ **Number of Dependents:**___

Position: ____________________________________ **Hire Date:**____/____/____ **Employment Status:**______

Pay Rate: $_________ **( ) Hourly ( ) Annual Date of Injury:**___/___/___ **Last Day Worked:**___/___/___

Time of Incident: _______ **AM ( ) PM ( ) Time Employee Began Work:** ______ **AM ( ) PM ( )**

Location of Accident:_________________________________ **Date Employer Notified:**___/___/___ **HR Dept.**
___/___/___ **Supervisor**

Part of Body Affected:____

Equipment / Chemicals used when accident occurred:____

Witness Name:_____________________________ **Ph#:**____________ **Dept:**___________________________
Witness Name:_____________________________ **Ph#:**____________ **Dept:**___________________________

Name of Supervisor:___________________________________ **Ext#:**________________

No Treatment ( )
Minor by Clinic ( )
Emergency Care ( )
Hospitalized ( )
Future Major Medical/Lost Time Anticipated ( )

Medical Provider: Name:____
Address:_______________________________________
State/City/Zip:____
Phone #:____

Were Safeguards or Safety Equipment Provided ( ) YES ( ) NO

How did Injury or Illness/ Abnormal Health Condition Occur?

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