

# FIRST REPORT OF INJURY

**To Be Completed by the Supervisor**  
Send copy to REM SAFETY SECTION/Civil



REPORT ALL WORKER'S COMPENSATION INJURIES TO LIBERTY MUTUAL  
The 1-800 CLAIMS SERVICE CENTER is open 24 hours a day including  
Weekends and Holidays. For efficient service, have the following  
**Information available for the Customer Service Representative.**  
**CALL: 1-800-275-4211**

**Attention:** This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state worker compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-595 and 29CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____
Title _____
Phone (____) _____-_____
Date ____/____/____

**Information about the employee**

- 1) Full name \_\_\_\_\_  
Social Security # \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_
- 2) Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_
- 3) Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_
- 4) Date hired \_\_\_\_/\_\_\_\_/\_\_\_\_
- 5) Male  
Female

**Information about the physician or other health care professional**

- 6) Name of physician or other health care professional \_\_\_\_\_  
\_\_\_\_\_
- 7) If treatment was given away from the worksite, where was it given?  
Facility \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- 8) Was employee treated in an emergency room?  
Yes  
No
- 9) Was employee hospitalized overnight as an in-patient?  
Yes  
No

**Information about the case**

- 10) Case number from the Log \_\_\_\_\_ (REM will assign)
- 11) Date of injury or illness \_\_\_\_/\_\_\_\_/\_\_\_\_
- 12) Time employee began work \_\_\_\_\_ AM/PM
- 13) Time of event \_\_\_\_\_ AM/PM Check if time cannot be determined
- 14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
- 15) **What happened?** Tell us how the injury occurred. *Examples:* "when ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
- 16) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
- 17) **What object or substance directly harmed the employee?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*
- 18) **If the employee died, when did death occur?** Date of death \_\_\_\_/\_\_\_\_/\_\_\_\_ (call REM immediately at 41425)

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**ADDITIONAL EMPLOYEE INFORMATION**

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OCCUPATION: SUPERVISOR: DATE/TIME SUPERVISOR NOTIFIED:  
PERSON NOTIFIED AT PURDUE: DEPARTMENT NUMBER (LOCATION CODE):  
EMPLOYMENT STATUS: FT Student HOURS/WEEK: MONTHLY WAGE: HOURLY WAGE: PAY PERIOD: Monthly  
PT Temp Bi-Weekly  
PAID FOR DATE OF INJURY? YES NO MARITAL STATUS: S. M. W. D. NO. OF DEPENDENTS:

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**ADDITIONAL ACCIDENT INFORMATION**

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LOST TIME? YES NO LAST DAY WORKED:  
FIRST FULL DAY OUT: (ESTIMATED) DATE RETURN TO WORK:  
EXACT LOCATION OF ACCIDENT (e.g. *Civil--Loading dock north end*):  
WERE OTHERS INJURED FROM THIS INCIDENT? YES NO IF YES, LIST NAMES AND PHONE #:  
WERE THERE ANY WITNESSES? YES NO  
WERE THERE UNSAFE ACT(S) OR FAILURE TO ACT BY EMPLOYEE(S)? IF YES DESCRIBE:  
YES NO  
WERE THERE MECHANICAL, PHYSICAL OR ENVIRONMENTAL CONDITIONS THAT CONTRIBUTED TO ACCIDENT? YES NO IF YES DESCRIBE:  
WAS PPE REQUIRED PER HAZARD ASSESSMENT FORM? YES NO IF YES LIST REQUIRED PPE:  
WAS REQUIRED PPE WORN? YES NO WAS PROPER PPE AVAILABLE? YES NO DID PPE FAIL? YES NO  
WHAT IS THE ROOT CAUSE OF THE ACCIDENT?

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CORRECTIVE ACTION REQUIRED:

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PARTY RESPONSIBLE FOR CORRECTIVE ACTION: DATE COMPLETED:

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**ADDITIONAL COMMENTS & INFORMATION**

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Employee wants sick leave only used to supplement other benefits.  
Employee wants vacation used to supplement after sick leave is exhausted.  
Employee does not want sick leave or vacation used to supplement other benefits.

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Claim number: Completed by:

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\* Disclosure of Employee's Social Security number is in accordance with IC22-3-4-13