# STATE OF NEW JERSEY
# EMPLOYER'S F RST REPORT OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE
# REPORTING INSTRUCTIONS

Print Form

This form must be completed by the injured employee and the supervisor within 24 hours of the accident in the following cases: (1) accidental injury causing an absence from work beyond the day of injury, or (2) medical treatment by a doctor or hospital, or (3) occurrence of an occupational disease due to working conditions whether or not time is lost. Mail promptly to your Human Resource office. in case of fatal or serious injury, (hospital admission), immediately notify the Human Resource office by telephone. Retain a copy for your records and forward all other copies to your Human Resource office per your departmental procedures.

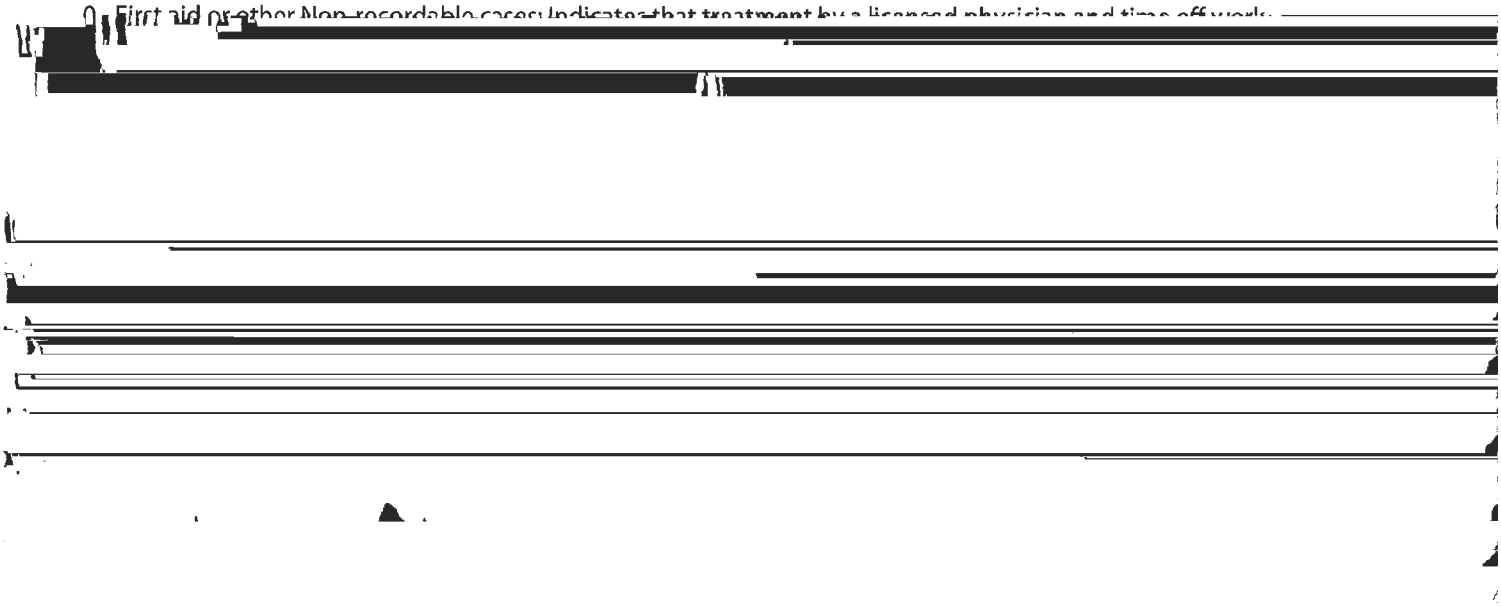
The Human Resource office shall review the report for completeness and accuracy and file the original no later than three days after the injury occurred with the Division of Risk Management Department of the Treasury.

NOTE: If the employee is too severely injured to complete the report, the employee's supervisor will complete the report within the 24 hour time span and submit it to Human Resources.

**ORIGINAL TO:** **DEPARTMENT OF THE TREASURY**
**DIVISION OF RISK MANAGEMENT**
**PO BOX 620**
**TRENTON NJ 08625-0620**

**INCIDENT CODE DEFINITIONS**

0 - First aid or other Non-recordable cases: Indicates that treatment by a licensed physician and time off work



were not necessary.
1 - Medical treatment case: Indicates that treatment by a licensed physician was required, but no time off work other than day of injury for recovery.
5 - Lost work day case: Indicates that time off work, beyond day of injury, for recovery was necessary.
9 - Fatality case: Employee died from injuries received.

**FOR EMPLOYEE'S SUPERVISOR USE**

## TABLE C - Unsafe Act or Hazardous Condition Classification

B1 -- Failure to use available personal protective equipment P -- Unsafe placing, mixing, combining, etc. (e.g. box improperly placed,
C1 -- e to wear safe l at ( g high heels, Q -- e lling on ee).
hair, long slee e c i ) e nt (e.g. tagged as defective or

# STATE OF NEW JERSEY
# EMPLOYER'S FIRST REPORT OF ACCIDENTAL NJURY OR OCCUPATIONAL DISEASE
## INFORMATION BELOW MUST BE COMPLETED BY THE EMPLOYEE AND

Claim Number | Injured Employee Last Name | First Name | M.I. | SS#/EIN# | Date of Birth | Sex

Address | City | County | Zip Code | Gross Biweekly Wage | Daily Wage

Acc. Date (mm/dd/yy) | Date Employee Stopped Work | Official Workstation | Phone No. Home

Day of Week | Time | O AM O PM | Date employee | O Estimate | Department | Phone No. Work

Place of accident or exposure | HR Name & Phone numbe

**Describe how the accident occurred in detail**

**Describe the injury or illness and part of body affected**

**Identify witnesses on the second page** | **Was employee referred to authorized physician?** | **Name of Treating Physician**

Did this accident happen because of the action of others who are not co-employees or because of defective equipment? If so, complete responsible party information on other side.

O Yes O No

34:15-57.4. Workers' compensation fraud: criminal and civil penalties.
A person shall be guilty of a crime of the fourth degree if the person purposely or knowingly makes, when making a claim for benefits pursuant to R.S. 34:15-1 et seq

## Explanation for using unauthorized Physician

[redacted]

Diagnosis

Is the injury related to the accident or work exposure? ○ Accident ○ Work Exposure

What further treatment is needed?

Date the employee is medically able to return to work (mm/dd/yyyy)

Are outside medical/pharmacy bills etc. anticipated? ○ Yes ○ No

Remarks

Date

Signature of Physician

## Witnesses to Accident

**Name** **Address**

## Responsible Party nformation

Name of person(s)

Identify object, machine, substance or premise

[redacted]

○ Yes ○ No

○ Yes ○ No