FIRST REPORT OF INJURY

Please complete and return to the **Insurance Department within 3 days of injury**

EMPLOYEE INFORMATION

Injured Employee Name _____ Date of Birth _____

Address _____ Phone Number _____

City, State, Zip _____ Hired Date _____

☐ Male ☐ Female | ☐ Married ☐ Single ☐ Divorced ☐ Widowed | ☐ Full Time ☐ Part Time | Number of Dependent Children Under 18 ____ | Date Reported to Employer _____

Direct Supervisor _____ Supervisor Work Phone _____

Job Title _____ School/Department _____

INJURY OR EXPOSURE INFOMATION To be filled out by the employee

Date of Injury _____ Time of Injury ____ : ____ ____ Injury Location _____

Names of Witnesses _____

Describe your Injury _____

Part Injured _____ ☐ RIGHT SIDE ☐ LEFT SIDE ☐ BOTH

How did the injury occur? ***Be detailed and specific.*** *If additional space is needed, please attach documentation to this form.*

_____

_____

TREATMENT INFORMATION * REQUIRED, Please select *

☐ Declined Treatment
☐ First Aid (ie: Band-Aid)
☐ Work Med Clinic
☐ Emergency Room
☐ Other Clinic (please list)

_____

If sent to a Medical Facility, employee MUST bring back a work status form from the physician's office.
If the physician has ordered work restrictions, please contact Insurance immediately.

As an employee, I understand that if my pain increases or I decide to seek further medical treatment, I will call Tristar Risk Management at (801)713-9140 ext 2211 beforehand. I also acknowledge that it is my responsibility to make sure I go to all my medical follow-ups, appointments, and follow physician recommendations. Finally, I acknowledge that I will speak directly to my supervisor and the Insurance Department at (801) 567-8070 if I am given restrictions by the treating physician or if I will be unable to work because of the injury.

Employee Signature *Date*

SUPERVISOR INVESTIGATION OF INJURY Answer all questions. Investigation may be required depending on severity of injury

· Has the employee been injured on the job before? ☐Yes ☐ No *If yes, explain* _____
· Was the injury reported immediately after if occured? ☐Yes ☐ No *If no, why?* _____
· Did you inspect the location/interview witnesses? ☐Yes ☐ No *If yes, please attach an explanation of your findings*
· Will safety measures/training be needed in the future? ☐Yes ☐ No *If yes, what?* _____
· Was equipment or apparatus involved in the injury? ☐Yes ☐ No *Specific Equipment* _____
If yes, Did equipment appear to be used appropriately? ☐Yes ☐ No
Was there any apparent malfunction of the equipment? ☐Yes ☐ No
· Is the employee's account of the incident accurate with the results of the investigation? ☐Yes ☐ No

As a supervisor, I acknowledge that it is my responsibility to be informed about this employee's restrictions and how the employee is recovering. I also acknowledge that ***I will inform the Insurance Department at (801)567-8070 immediately if the employee misses a day at work at anytime due to this injury****. I also am aware that it is my responsibility to remain in contact with the employee if the employee is unable to return to work and document contracts made (phone log provided on reverse side of this form).*

Supervisor Signature (if not Principal/Director) *Date*

Principal/Director Signature *Date*