TO REPORT AN INJURY: CALL 800-831-9531

24 HOURS A DAY / 7 DAYS A WEEK

FIRST REPORT OF INJURY (FROI)

EMAIL or FAX FORM TO: IntakeDepartment@FirstMCO.com | 973-257-2282

Date:			
Name of Business/Employer:			
Address:	City:	ST:	Zip:
Name of Employer Contact:	Phone:		

INJURED EMPLOYEE

Name:	Sex: Male Female		
Phone:	Cell:		
Address:	City:	ST:	Zip:
Social Security #:	Date of Birth:		
Department:	Occupation/Job Title:		
Date of Hire:	Employment Status: Full-time Part-time Volunteer		
# of hours work per week: Shift:	Salary:		

INJURY INFORMATION

Date of Injury:	Time of Injury: AM PM		
Location of Injury:	City:	ST:	Zip:
Date Reported:	To Whom:		
Date Last Work:	Date Last Paid:	Date Return to Work:	
Type of Injury:			
Body Part(s) Affected:			
Did injury/illness/exposure occur on employer's premises? Yes No			
How did the injury occur? Describe the sequence of events that directly injured the employee. (List all equipment, materials or chemicals used/specify activity/work process when injury occurred)			
Name of Hospital/Treating Facility:			
Address:	City:	ST:	Zip:
Date of Treatment:			
Initial Treatment: (check one) No medical treatment Minor: Treatment by Employer Minor: Clinic or Hospital Emergency Care Hospitalized greater than 24 hours Future major medical/lost time anticipated			
Is follow-up treatment needed: Yes No			
Were there any witness(es): Yes No			
Name of witness(es) (if applicable):			
Witness Phone Number:			
Were there any prior workers' compensation injuries:			