WorldSource

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FOREIGN VOLUNTARY WORKERS' COMPENSATION
EMPLOYER'S FIRST REPORT OF ACCIDENT/OCCUPATIONAL DISEASE

Employers

1. Name of Employer _____
2. Mailing Address:. _____ City or Town _____ State _____ Zip _____
3. Contact person: _____ Phone No: _____
4. Fax No: _____ E-Mail Address: _____

Time and Place

5. (a) Location where accident occurred: _____ (b) Was accident on Employer's premises? _____
   (c) Employee's Department name _____
   (d) Did accident occur on or off shore? _____ If off shore, on what type of vessel: _____
   (e) Dept./Rig No./Location Code: _____
6. Date of Injury _____ 20 _____ Time of Accident: _____ A.M. _____ P.M.
7. Date disability began _____ 20 _____
8. Was injured paid in full for this day: _____
9. Has Employee returned to work? _____ If yes, give date: _____
10. Date Employer first know of injury: _____
11. Name of foreman: _____

Injured Person

12. Name of Injured _____ (Soc. Sec. No.) _____
    (First Name) (Middle Initial) (Last Name)
13. Mailing Address: _____ City or Town _____ State _____ Zip _____
14. **Check (√) one:** Married π ; Single π ; Widowed π ; Widower π ; Divorced π **Check (√) one:** Male π , Female π
15. Telephone No: _____ Nationality _____ Speak English: _____
16. Date of Birth/Age: _____
17. (a) Occupation when injured _____ (b) Was this his/ her regular occupation _____
    (If not, state department or branch where regularly employed) _____
18. (a) Date hired/Yrs. employed _____ (b) Part or full time: _____ (c) Wages per hour $ _____
    (d) Hours worked per day: _____ (h) Days worked per week: _____ (i) Average wkly/mthly wages _____

Cause of Injury

19. Was accident caused by injured's failure to use or observe safety appliance or regulation _____
20. Describe fully how accident occurred, and state what employee was doing when injured _____
21. Name and address of witnesses _____

Nature of Injury

22. Nature and location of injury (describe fully exact location of amputations or fractures, right or left) _____
23. Did you provide medical attention _____
24. (a) Name and address of physician _____
    (b) Name and address of hospital _____

Fatal Cases

25. Has injured died due to this injury _____ If so, give date of death _____
26. Name and address of nearest relative known: _____

Date of this report _____ **Firm Name** _____

Telephone No: _____ **Fax No:** _____

Signed by: _____ **Official Title** _____