

FRANKLIN PIERCE UNIVERSITY

Worker's Compensation – First Report of Injury

EMPLOYER INFORMATION

Employer Name: Franklin Pierce University		Nature of Business: University
Address: 40 University Drive Rindge, NH 03461-0060	Telephone: (603) 899-4075	WC Insurance Company: MEMIC 1750 Elm Street Suite 500 Manchester, NH 03104

EMPLOYEE INFORMATION

Name of injured: First		Middle Initial	Last		CLAIM #: (HR use)
SS No.:		DOB:	Gender: M F	Date & Time of Injury:	Today's Date:
Address: No. & St.		City/Town		State:	Zip Code:
Tel. No.:		Employment Status: Regular Part-Time	Date of hire: ____/____/____	No. of Dependent Children:	Total Dependents:
Position:	Department:	# days worked per week:	No. hrs. worked per week:	Time workday began:	

INJURY OR ILLNESS INFORMATION

Has injured died? If so, what date?	Part(s) of body injured:	Object/substance causing injury:
Describe fully how accident occurred and describe what employee was doing before and during incident:		
Please categorize the injury/illness as one of the following: Injury <input type="checkbox"/> Skin Disorder <input type="checkbox"/> Respiratory condition <input type="checkbox"/> Poisoning <input type="checkbox"/> Hearing Loss <input type="checkbox"/> All other Illnesses <input type="checkbox"/>		
Date of Initial Treatment: ____/____/____ No medical treatment: ____ Care provide by Employer only (on-site): ____ *Emergency care: ____ *Hospitalized: ____ *Outpatient: ____ *Clinic: ____ *Office Visit: ____ <i>*Please provide name of physician/medical facility and return pink workers compensation form to HR as soon as possible.</i>		
*Name of treating hospital:		*Name of treating physician:
Location where accident occurred:	Witness(es):	Person Notified:
Date Notified:		
If applicable: Was there anybody else injured in this incident?		
Employee Signature:		Date of this report:
Employer Signature:		Printed/Typed Name and Official Title:

For Human Resources Use Only

Date disability began:	Date Disability Ended	Returned at Alternative/Light Duty: Yes No
If injured has not returned to work, what is the expected return date?		If so, how many days? _____
		Preparer's Initials: