## FRANKLIN PIERCE UNIVERSITY Worker's Compensation – First Report of Injury

Martial Status:   Status:   Dobe   Sta	EMPLOYER INFORMATION									
## Add Display Control   (603) 899-4075   1750 Elm Street Suite 500   Manchester, NH 03104    ## EMPLOYEE INFORMATION    Name of injured: First   Middle Initial   Last   CLAIM #:   HR 0400      SS No.:	Employer Name: Franklin Pierce University			ersity	Nature of E	Business: l	Jniversity			
Manchester, NH 03461-0960										
Name of injured: First   Middle Initial   Last   CLAIM #: (HE use)			(603) 899-4075							
Name of injured: First   Middle Initial   Last   ClAIM #: per use)										
SS No.:    DOB:   Gender:   Date & Time of Injury:   Today's Date:										
Address: No. & St. City/Town Status: Date of hire: No. of Dependent Children: Total Dependents:    Regular   Part-Time  /   No. of Dependent Children: Total Dependents:   Regular   Part-Time  /   No. hrs. worked per week: Department:   # days worked per week: No. hrs. worked per week: Department:   Time workday began:	CLAIM #. (HR use)									
Address: No. & St.	SS No.:			DOB:		Gender:	Date & Time of Injury:		Today's Date:	
Tel. No.:    Employment Status:   Regular   Part-Time   Part-Time				M		M F				
Regular   Part-Time  /   No. hrs. worked per week:   No. hrs. worked per week:   Department:   # days worked per week:   No. hrs. worked per week:   Department:   Began:   Department:   Began:   Department:   Began:   Department:	Address: No. & St. City/Town			Sta		State:	Zip Code:		Marital Status:	
Regular   Part-Time  /   No. hrs. worked per week:   No. hrs. worked per week:   Department:   # days worked per week:   No. hrs. worked per week:   Department:   Began:   Department:   Began:   Department:   Began:   Department:							N (1	2 1 (01:11	TILD	
Position: Department: # days worked per week: No. hrs. worked per week: 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 Skin Disorder Respiratory condition Poisoning Hearing Loss All other Illnesses  Part (s) of body injured: Object/substance causing injury:  Please categorize the injury/illness as one of the following:  Injury No medical treatment: Care provide by Employer only (on-site):   "Emergency care: Hospitalized: Outpatient: Cinic: Office Visit:   "Please provide name of physician/medical facility and return pink workers compensation form to HR as soon as possible.  "Name of treating hospital: "Name of treating physician:  Location where accident Occurred: Person Notified: Date Notified:  If applicable: Was there anybody else injured in this incident?  Employee Signature: Printed/Typed Name and Official Title:	Tel. No.: Employment Status:			Date of	hire:		No. of Dependent Children:		Total Dependents:	
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Employer Signature: Printed/Typed Name and Official Title:	If applicable: Was there anybody else injured in this incident?									
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For Human Resources Use Only	Employer Signature:				Printe	Printed/Typed Name and Official Title:				
	For H	uman Resou	ırces Use	Only						

Date disability began:

Date Disability Ended

Returned at Alternative/Light Duty:

Yes No

If so, how many days?

If injured has not returned to work, what is the expected return date?

Preparer's Initials: