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:	Marital Status:
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 ☐ Skin Disorder ☐ Respiratory condition ☐ Poisoning ☐ Hearing Loss ☐ All other Illnesses ☐

Date of Initial Treatment: __/___/_____ No medical treatment: _____ Care provide by Employer only (on-site): ____

*Emergency care: ____ *Hospitalized: ____ *Outpatient: ____ *Clinic: ____ *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:	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 so, how many days? _____	
If injured has not returned to work, what is the expected return date?			Preparer's Initials: