

**STATE OF NEW JERSEY
EMPLOYER'S FIRST REPORT OF ACCIDENTAL INJURY OR OCCUPATIONAL ILLNESS**

	1A. POLICY NUMBER	1B. EFFECTIVE DATE	EXPIRATION DATE
	2. DATE OF INJURY OR ILLNESS	TIME OF DAY __ a.m. __ p.m.	SEND REPORT IMMEDIATELY AFTER INJURY DO NOT WAIT FOR DOCTOR'S REPORT
MAIL DUPLICATE			
← (YELLOW) TO			
	O.S.H.A. CASE NUMBER		

THIS FORM (IN QUADRUPPLICATE) MUST BE COMPLETED IN THE FOLLOWING CASES ONLY:

(1) FOR EVERY ACCIDENTAL INJURY OF ILLNESS WHICH SHALL CAUSE A LOSS OF TIME FROM REGULAR DUTIES BEYOND THE WORKING DAY OR SHIFT INCLUDING SUNDAY OR ANY DAY ON WHICH EMPLOYEE WOULD USUALLY WORK, OR

(2) WHICH SHALL REQUIRE MEDICAL TREATMENT BEYOND ORDINARY FIRST AID, OR

(3) FOR THE OCCURRENCE OF AN OCCUPATIONAL ILLNESS WHETHER OR NOT TIME IS LOST.

COMPLETE THIS FORM IN ACCORDANCE WITH THE INSTRUCTIONS ON BACK OF THIS WHITE SHEET. MAIL IT PROMPTLY AS POSSIBLE. IN ALL CASES NO LATER THAN THE START OF THE SECOND (2nd) WORK DAY AFTER OCCURRED, IN CASE OF A FATAL OR SERIOUS INJURY (one that requires hospitalization) COMPLETE AND MAIL THIS IMMEDIATELY.

**PLEASE PRINT OR TYPE
SEE DETAILED INSTRUCTIONS ON REVERSE SIDE (White Sheet)**

E M P L O Y E R	3. FIRM NAME	4. EMPLOYER'S REGISTRATION	5. S.I.C.	6. NO. of EMPLOYEES	
	7. MAILING ADDRESS (Please include City, Zip)	8. TELEPHONE NO. (Area Code)	9. NATURE OF BUSINESS		
		LOCATION, IF DIFFERENT FROM MAIL ADDRESS			
E M P L O Y E E	10. NAME: LAST -FIRST - MIDDLE NAME	11. SOCIAL SECURITY NO.	12. Date of Birth Mo. Da. Yr.	13. AGE	14. SEX Male Female
	15. HOME ADDRESS (# & Street, City, Zip, County)	16. OCCUPATION (Regular Job Title)	17. DEPARTMENT WHERE EMPLOYED?		
	18. TELEPHONE NO. (Area Code)	19. WAGES Weekly \$ _____ Hourly \$ _____	20. NO of HRS. (Regular work day)		

I N J U R Y O R I L L N E S S	21. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (Address, City, County)					
	22. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Be Specific) (Please use separate sheet if necessary)					
	23. OBJECT OR SUBSTANCE, MACHINE OR TOOL THAT DIRECTLY INJURED EMPLOYEE					
	24. NATURE OF INJURY OR ILLNESS AND PART OF BODY AFFECTED (Formal Diagnosis Not Required)					
	25. DID EMPLOYEE DIE? <input type="checkbox"/> Yes, date _____ No	26. WAS EMPLOYEE UNABLE TO WORK ON ANY DAY AFTER INJURY? Yes _____ No _____		27. HAS EMPLOYEE RETURNED TO WORK? Yes, date _____ No _____		
	28. NAME OF TREATING DOCTOR, IF ANY		29. DOCTOR'S ADDRESS (Number and Street, City, Zip)			
30. IF HOSPITALIZED, Name of Hospital		31. ADDRESS OF HOSPITAL (Number and Street, City, Zip)				

NEW JERSEY DEPARTMENT OF LABOR CN 381 Trenton, NJ 08625-0381	COMPLETED BY: (Print or Type)	TITLE:
	SIGNATURE:	DATE: