STATE OF NEW JERSEY
EMPLOYER'S F RST REPORT OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE
REPORTING INSTRUCTIONS

Print Form

This form must be completed by the injured employee and the supervisor within 24 hours of the accident in the following cases: (1) accidental injury causing an absence from work beyond the day of injury, or (2) medical treatment by a doctor or hospital, or (3) occurrence of an occupational disease due to working conditions whether or not time is lost. Mail promptly to your Human Resource office. in case of fatal or serious injury, (hospital admission), immediately notify the Human Resource office by telephone. Retain a copy for your records and forward all other copies to your Human Resource office per your departmental procedures.

The Human Resource office shall review the report for completeness and accuracy and file the original no later than three days after the injury occurred with the Division of Risk Management Department of the Treasury.

NOTE: If the employee is too severely injured to complete the report, the employee's supervisor will complete the report within the 24 hour time span and submit it to Human Resources.

ORIGINAL TO: **DEPARTMENT OF THE TREASURY**
DIVISION OF RISK MANAGEMENT
PO BOX 620
TRENTON NJ 08625-0620

INCIDENT CODE DEFINITIONS

0 - First aid or other Non-recordable cases: Indicates that treatment by a licensed physician and time off work were not necessary.
1 - Medical treatment case: Indicates that treatment by a licensed physician was required, but no time off work other than day of injury for recovery.
5 - Lost work day case: Indicates that time off work, beyond day of injury, for recovery was necessary.
9 - Fatality case: Employee died from injuries received.

FOR EMPLOYEE'S SUPERVISOR USE

TABLE C - Unsafe Act or Hazardous Condition Classification

B1 -- Failure to use available personal protective equipment

C1 -- e to wear safe l at (g high heels, hair, long slee e c i)

P -- Unsafe placing, mixing, combining, etc. (e.g. box improperly placed, e lling on ee).

Q -- e nt (e.g. tagged as defective or

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INFORMATION BELOW MUST BE COMPLETED BY THE EMPLOYEE AND

Claim Number	Injured Employee Last Name	First Name	M.I.	SS#/EIN#	Date of Birth	Sex

Address	City	County	Zip Code	Gross Biweekly Wage	Daily Wage

Acc. Date (mm/dd/yy)	Date Employee Stopped Work	Official Workstation	Phone No. Home

Day of Week   Time   AM   PM   Date employee   Estimate   Department   Phone No. Work

Place of accident or exposure

HR Name & Phone number

Describe how the accident occurred in detail

Describe the injury or illness and part of body affected

Identify witnesses on the second page

Was employee referred to authorized physician?

Name of Treating Physician

Did this accident happen because of the action of others who are not co-employees or because of defective equipment? If so, complete responsible party information on other side.

Yes   No

34:15-57.4. Workers' compensation fraud: criminal and civil penalties.
A person shall be guilty of a crime of the fourth degree if the person purposely or knowingly makes, when making a claim for benefits pursuant to R.S. 34:15-1 et seq

Explanation for using unauthorized Physician

Staff Physician's/Nurses's remarks (for agency medical staff use)

Diagnosis

Is the injury related to the accident or work exposure? ○ Accident ○ Work Exposure

What further treatment is needed?

Date the employee is medically able to return to work (mm/dd/yyyy)

Are outside medical/pharmacy bills etc. anticipated? ○ Yes ○ No

Remarks

Date

Signature of Physician

Witnesses to Accident

Name	Address

Responsible Party Information

Name of person(s)

Identify object, machine, substance or premise

○ Yes ○ No

○ Yes ○ No