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

1. CARRIER NAME. ADDRESS	IA. POLICY NUMBER	1B. EFFECTIVE DATE	EXPIRATION DATE
	2. DATE OF INJURY OR ILLNESS	TIME OF DAY	**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 QUADRUPLICATE) 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 INJURY 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)

☐ New Jersey Registration No.
or
☐ Federal Employer identification No.

EMPLOYER

3. FIRM NAME	4.	5. S.I.C. NO.	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		

EMPLOYEE

10. NAME: LAST NAME - FIRST NAME MIDDLE NAME	11. SOCIAL SECURITY NO.	12. Date of Birth Mo. Day Yr	13. AGE	14. SEX ☐ Male ☐ Female
15. HOME ADDRESS (Number and 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)			

INJURY OR ILLNESS

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. 010 EMPLOYEE DIE?	26. WAS EMPLOYEE UNABLE TO WORK ON ANY DAY AFTER INJURY?	27. HAS EMPLOYEE RETURNED TO WORK?
☐ **Yes.** date _____	☐ Yes, date last worked _____	☐ Yes, date _____
☐ No	☐ No	☐ 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)

IMPORTANT NOTICE OF SPECIAL FILING RIGHTS FOR UNEMPLOYMENT INSURANCE BENEFITS

The New Jersey Unemployment Compensation Law provides special filing rights for workers upon recovery from a work-related injury or illness.

Eligibility for unemployment insurance benefits may be based upon wages earned prior to your disability.

NOTE. THESE BENEFITS ARE POTENTIAL UNEMPLOYMENT INSURANCE BENEFITS. YOU SHOULD CONTACT THE DIVISION OF PROGRAMS - UNEMPLOYMENT AND DISABILITY INSURANCE FOR ADDITIONAL INFORMATION. DO NOT CONTACT THE DIVISION OF WORKERS' COMPENSATION.

COMPLETED BY: (Print or Type)	TITLE:
SIGNATURE:	DATE:

NEW JERSEY DEPARTMENT OF LABOR
DIVISION OF WORKERS' COMPENSATION
CN 381
TRENTON, NEW JERSEY 08625-0381

MAIL ORIGINAL (White) TO

BLUE COPY RETAINED BY EMPLOYEE.
PINK COPY FOR PERSONNEL RECORDS.

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

L & 1-1 (R-6-92)

INSTRUCTIONS

1 . CARRIER NAME, ADDRESS: Indicate the name and address of the firm's Workers' Compensation carrier. if self-insured, indicate *self-insured".

1A. POLICY NUMBER: Indicate the firm's Workers' Compensation Insurance policy number.

1B. EFFECTIVE DATE: Indicate the date when the present policy started.

EXPIRATION DATE: Indicate the date when the present policy expires.

2. DATE OF INJURY OR ILLNESS: Indicate the date when the injury occurred or in case of illness, when first detected.

TIME OF DAY: Indicate the time of injury or illness (i.e. 9:30 a.m. or 7:00 p.m.)

O.S.H.A. CASE NUMBER: (Leave Blank)

3. FIRM NAME: Indicate the full name of individual, partnership, corporation or trade name of the employer.

4. NEW JERSEY REGISTRATION NUMBER OR FEDERAL EMPLOYER IDENTIFICATION NUMBER: Indicate **either** your company's New Jersey Registration Number or your company's Federal Employer Identification Number. This number can be obtained from your copy of Quarterly Report of Wages (Form U.C. 27B). The account number is on the fifth line of the address.

S. S.I.C. Number: Indicate the S.I.C. Number of your firm. This number can be obtained from your copy of Quarterly Report of Wages (Form U.C. 27B). The S.I.C. isthe four digit number in the lower right hand corner of the address under the account number.

6. NO. OF EMPLOYEES: The number of employees employed by the firm.

7. MAILING ADDRESS: The address of the employer.

8. TELEPHONE NO. (AREA CODE): The business telephone of the employer.

9. NATURE OF BUSINESS: Describe the kind of business of the employer, i.e. manufacture shoes, wholesale food, retail clothing, construction, transportation, communication, utilities, government, etc.

LOCATION, IF DIFFERENT FROM MAILING ADDRESS: If the location where the injury or illness occurred is different from the mailing address of the employer in question #3.

10. NAME: Indicate the full name of the employee as carried on payroll records.

11. SOCIAL SECURITY NO.: Indicate the Social Security number of the employee.

12. DATE OF BIRTH: **13. AGE:** **14. SEX: (Self-explanatory)**

15. HOME ADDRESS: The address of the employee.

16. OCCUPATION: The job classification of employee, i.e., carpenter, electrician, driver, lathe operator, salesperson, etc.

17. DEPARTMENT-WHERE EMPLOYED: indicate under which agency within the firm that the employee worked.

18. TELEPHONE NO.-, The home telephone of employee.

19. WAGES: if employee is paid weekly salary indicate gross weekly amount. If employee is paid hourly indicate hourly rate. (exclude overtime)

20. NO. OF HOURS: Indicate the total regular number of hours employee works per day. (exclude overtime)

21. WHERE DID ACCIDENT OR EXPOSURE OCCUR? If the location of accident or exposure is different from the address shown on line 7, give sufficient information to pinpoint location by giving address, city, county, route orjob location.

22. WHAT WAS EMPLOYEE DOING WHEN INJURED? Examples: walking down stairs, climbing ladder, operating table saw, changing wheel on grinder, sitting at desk, opening file drawer, etc.

23. OBJECT OR SUBSTANCE, MACHINE OR TOOL THAT DIRECTLY INJURED EMPLOYEE Examples: stairs and handrail, floor, saw blade, dust, vapors, chips, chisel, hammer, chain, acid (name), steam, fire, hot sluge, electric current, the item employee was lifting, pushing or pulling, etc.

24. NATURE OF INJURY OR ILLNESS AND PART OF BODY AFFECTED Examples: amputation of right index finger, fracture of ribs, burn of left hand, contusions of both legs, laceration of upper right arm, etc.

Examples of occupational disease: dermatitis of neck, silicosis, etc.

25. DID EMPLOYEE DIE? Was the injury or illness the cause of death?

26. WAS EMPLOYEE UNABLE TO WORK ON ANY DAY AFTER INJURY? (Self-explanatory).

27. HAS EMPLOYEE RETURNED TO WORK? (Self-explanatory).

28, 29, 30, 31 (Self-explanatory)