MANHEIM TOWNSHIP
WORKERS' COMPENSATION – FIRST REPORT OF INJURY FORM

Social Security Number:		Date of Injury	
Employee First Name:		Employee Last Name:	
Employee Address (Street, City, State, Zip Code and County)			
Employee Contact Number:	Employee Gender:	Employee Marital Status:	Number of Dependents:
Employee Date of Birth:	Employee Occupation or Job Title		
Last Date Worked:	Date Disability Began / First Day out of work for work injury:	Date Employee Notified Employer of Injury:	
Time of Injury		Accident Site County / Where did accident occur	
Number of Days Employee Works Per Week: Hours Schedule to Work Per Week:		Time Employee Began Work:	

TYPE OF INJURY / ILLNESS (sprain, strain, slip & Fall, etc)
PART OF BODY AFFECTED (upper body parts, legs, hand, wrist, etc)
PHYSICAL DESCRIPTION OF WHERE INCIDENT OCCURRED

CAUSE OF INJURY (provide detail information about the injury)
Were Safeguards or Safety Equipment Provided?
Were Safeguards or Safety Equipment Used?
All Equipment, Materials, or Chemicals Employee Was Using when Accident or Illness Exposure Occurred
How Injury or Illness/Abnormal Health Condition Occurred. Describe the Sequence of Events and Include any Objects or Substances Directly Responsible

INITIAL TREATMENT (first aid, Emergency Visit, Family Practice, Urgent Care, Specialist, etc)	Physician/Health Care Provider (if medical practice, name of practice) First Name: Last Name: Street: City, State, Zip Code:
HOSPITAL Name: Street: City, State, Zip Code:	WITNESS NAME First Name: Last Name: Contact Number:

Employee Signature:	Date
If Employee is unable to sign this document, name and contact number of person completing this form on behalf of the employee:	Date

TO BE COMPLETED BY HUMAN RESOURCES

Has Employee Returned to work?	Date Employee Returned to Work?	Salary Continue?
Hourly Rate: Weekly Salary: Annual Salary:	Exempt / Non-Exempt Date of Hire:	Status (Full-Time, Part-Time, Seasonal) / working hours per week