# Worksite Employer: First Report of Injury Worksheet

Complete all of the parts indicated by **bold** characters that you are able and fax worksheet to Terra Firma at 303-861-0377, or call Dave Wood at 720-974-7824 or your Account Manager. Please provide as much detail as possible.

| Critical Information | | | |
|---|---|---|---|
| **Business name:** | | | |
| **Business address:** | | | |
| IW SSN: | | | |
| **Accident date:** | | | |
| **IW name:** | | | |
| **Preparer name/title:** | | | |
| **Preparer e-mail:** | | | |
| **Preparer phone/fax:** | Phone: | FAX: | |

| Injured Worker (IW) | | | |
|---|---|---|---|
| IW home phone: | | | |
| IW home address: | | | |
| DOB: | | Sex: ☐ M ☐ F | |
| Marital status: | ☐ Single ☐ Married ☐ Divorced | **Language:** ☐ Eng ☐ Span Other: | |
| Occupation: | | | |
| DOH: | | Employee status: ☐ FT ☐ PT ☐ Temp | |
| Wage rate: | $ | Wage rate: ☐ hourly ☐ weekly ☐ monthly ☐ annual | Days worked per day/week: |

| Accident | | |
|---|---|---|
| **Acc. on premises?** | ☐ Yes ☐ No | |
| **Accident address:** | | **State/Zip:** |
| **Employer notified:** | | **Date notified:** |
| **How did injury occur?** | | |
| **Activity engaged in:** | | |
| **Equipment in use:** | | |
| **Body part injured:** | | Lost time claim? ☐ Yes ☐ No |

| Injury | | | |
|---|---|---|---|
| **Time of injury:** | | | **Time work began:** |
| **Last work date:** | | | **Full pay on day of injury:** ☐ Yes ☐ No |
| **Returned to work:** | ☐ Yes ☐ No | **Date returned to work:** | **Estimated date of return to work:** |
| **Witness name:** | | | **Witness phone number:** |
| **Claim questioned?** | ☐ Yes ☐ No | **Possible drugs or alcohol involved?** ☐ Yes ☐ No | |
| **Was safety equipment provided?** ☐ Yes ☐ No | | **Was safety equipment used?** ☐ Yes ☐ No | |

| Medical | | |
|---|---|---|
| **Medical treatment:** | ☐ No medical treatment ☐ Employer (first aid) ☐ Walk-in clinic ☐ Urgent Care ☐ Hospital ER | |
| **Hospitalized?** | ☐ Yes ☐ No | Possible surgery? ☐ Yes ☐ No |
| **Primary Care Provider:** | | |
| **PCP Address & Phone:** | | |

| Additional | | |
|---|---|---|
| **Was injury fatal?** | ☐ Yes ☐ No | **Date of death:** |
| **Comments:** | | |