FutureComp®

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FIRST REPORT OF INJURY FORM: TO BE COMPLETED BY EMPLOYEE, REVIEWED AND SIGNED BY SUPERVISOR FOR ACCURACY

1. EMPLOYEE Name (Last, First, MI)		2. Phone Number	3. Social Security Number
4. Home Address (No & Street, City, State Zip Code)		5. Marital Status ☐ Single ☐ Married	6. Number of Dependents
7. Date of Hire (MM/DD/YY):	8. Date of Birth (MM/DD/YY):	9. Sex ☐ Male ☐ Female	10. Hourly Wage $
11. Hours Worked Per Day ☐ FT ☐ PT	12. Days Worked Per Week	13. Average 52-Week $_____ ☐ Estimated ☐ Actual	
14. EMPLOYER Address (No & Street, City/State/Zip)		15. Employer Telephone	16. Department Employee Works:
17. Employer Name/Insurance Carrier: Name and Address of Branch Responsible for This Case (Not Local Agent or Adjuster) **ABC MA c/o FutureComp, 711 E. Main St, Suite 201, Chicopee, MA 01020**			

18. Date of Injury MM/DD/YY):	19. Time of Injury _____☐A.M. ☐ P.M.	20. Source of Injury (e.g., Machine, Tool, Substance, etc.)	
21. Address/Building/School Name where Injury Occurred		22. On Employer's Premises: ☐ Yes ☐ No Where? i.e. stairway, parking lot, classroom, curb, street	
23. Hospital Name/Treating Doctor Name and Address		24. Regular Occupation	25. Regular Occupation when Injured? ☐ Yes ☐ No
26. Name of Supervisor to Whom Was Injury Reported:		27. Date Reported (MM/DD/YY):	
28. **DESCRIBE IN DETAIL How Injury Occurred (***I was walking down stairs and……)*			
29. Injured Body Part(s) Left Arm, Right Leg, Back and Hip		30. Nature of Injury(ies) (Burn, Fracture, Fall, Cut, Strain)	
31. Witnesses to the Accident			

SIGNATURES

32. **EMPLOYEE'S** Name/Title	33. Employee's Signature and Date (MM/DD/YY): _____ _____
34. **SUPERVISOR'S** Name/Title:	35. Supervisor's Signature and Date (MM/DD/YY): _____ I have Reviewed This Form for Accuracy
36. **PREPARER'S** Name/Title (if Employee is unable to complete and if so, provide reason)	37. Preparer's Signature and Date _____ _____

EMPLOYEE RETURN TO WORK

Date Employee Returned to Work (MM/DD/YY)	Returned to Regular Occupation ☐ Yes ☐ No