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FIRST REPORT OF INJURY

PLEASE FAX INJURY REPORT TO: 336-497-5133 OR EMAIL: CLAIMS@CONGRUITYHR.COM

EMPLOYER NAME: DATE OF INCIDENT:

ADDRESS:

CITY: STATE: ZIP CODE:

SUPERVISOR NAME:

EMAIL ADDRESS:

ATTENTION:

This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains. In addition, this form is required for each injury/illness recorded on your OSHA 300 log, regardless of whether or not the injury/illness is compensable per Workers' Compensation.

SECTION 1: INJURED OR ILL EMPLOYEE INFORMATION

DATE OF INJURY/ILLNESS: TIME: AM ☐ PM ☐

NAME: MALE ☐ FEMALE ☐

ADDRESS: PHONE:

CITY: STATE: ZIP:

TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY: AM ☐ PM ☐

SECTION II: MEDICAL TREATMENT RENDERED:

DATE EMPLOYEE RECEIVED MEDICAL TREATMENT:

☐ **REFUSED BY EMPLOYEE** **EMPLOYEE SIGNATURE IF REFUSED:** **DATE:**

NAME OF MEDICAL FACILITY EMPLOYEE REFERRED TO:

PHYSICIAN NAME:

ADDRESS: STATE: ZIP:

PHONE:

PLEASE DESCRIBE WHAT HAPPENED:

WERE THERE ANY WITNESSES? PLEASE PROVIDE NAME AND CONTACT INFORMATION:

1.

2.

3.

PLEASE NOTE THAT UPON ARRIVAL AT MEDICAL FACILITY, ALL BILLING SHOULD BE FORWARDED TO:

CONGRUTIY HR

508 ARBOR HILL ROAD

KERNERSVILLE, NC 27284

FAX: 336-497-5133

EMAIL: CLAIMS@CONGRUITYHR.COM