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

1. CARRIER NAME. ADDRESS			IA.	IA. POLICY NUMBER			1B. EFFECTIVE DATE			EXPIRATION DATE		
			2. [2. DATE OF INJURY OR I		LNESS	TIME	TIME OF DAY		SEND REPORT		
								_			-	
		-	(YELLOW) TO					AFTER INJURY DO NOT WAIT FOR				
				O.S.H.A. CASE NUMBER				DOCTOR'S REPORT				
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.											THE	
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)												
E M P	3. FIRM NAME 7. MAILING ADDRESS (Please include City, Zip)			4. Federal Employer identification No.				5. S.I.C. NO. 6. NO. OF EMPLOYEES				
				8. TELEPHONE NO. (Area Code)				9. NATURE OF BUSINESS				
LOYER				LOCATION, IF DIFFERENT FROM N				IAIL ADDRESS				
E M P	10. NAME: LAST NAME - FIRST NAME MIDDLE NAME			11. SOCIAL SECURITY NO.				12. Date of Birth		13. AGE	14. SEX Male	
	15. HOME ADDRESS (Number and Street, City. Zip, County)			16. OCCUPATION (Regular Job Title)			Title)	Mo. Day	Yr MEN			
LOY EE		. WAGES ekly \$ Hou	ırly \$	20. NO. o	of HRS. (Regu	lar work da	ay)	EMPLO				
	21. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (Address, City, County)											
I	22- WHAT WAS EMPLOYEE DOING WHEN INJURED? (Be Specific) (Please use separate sheet if necessary)											
N J U												
۰Ř Y	23. OBJECT OR SUBSTANCE, MACHINE OR TOOL THAT DIRECTLY INJURED EMPLOYEE											
ο	24. NATURE OF INJURY OR ILLNESS AN	ed)										
R	R											
i							_	MPLOYEE RETURNED TO WORK?				
L				last worked			No					
N E				R'S ADDRESS: (Number and Street. City. Zip)								
S S	30. IF HOSPITALIZED. Name of Hospital		S OF HOSPITAL (Number and Street. City. ZIP)									
IMPORTANT NOTICE OF SPECIAL FILING RIGHTS				COMPLETED BY: (Print or Type)				TITLE:				
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.				SIGNATURE:				DATE:				
				NEW JERSEY DEPARTMENT OF LABOR								
	Eligibility for unemployment insurance bene		DIVISION OF WORKERS' COMPENSATION									
	wages earned prior to your disability.		CN 381 ORIGINAL (White) TO									
NOTE. THESE BENEFITS ARE POTENTIAL UNEMPLOY- MENT INSURANCE BENEFITS. YOU SHOULD CON- TACT THE DIVISION OF PROGRAMS - UNEMPLOY- MENT AND DISABILITY INSURANCE FOR ADDITIONAL INFORMATION. DO NOT CONTACT				TRENTON, NEW JERSEY 08625-0381								
				BLUE COPY RETAINED BY EMPLOYEE. PINK COPY FOR PERSONNEL RECORDS.								
	THE DIVISION OF WORKERS' COMPE	FILL	FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY									

INSTRUCTIONS

- 1. CARRIER NAME, ADDRESS: Indicate the name and address of the firm's Workers' Compensation carrier. if self-insured, indicate *self-insured".
- **<u>1A. POLICY NUMBER</u>**: 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.
- <u>4. NEW JERSEY REGISTRATION NUMBER OR FEDERAL EMPLOYER IDENTIFICATION NUMBER:</u> Indicate <u>either your</u> 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. is the 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.
- <u>9. NATURE OF BUSINESS:</u> 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)