

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

1. CARRIER NAME. ADDRESS	IA. POLICY NUMBER	1B. EFFECTIVE DATE	EXPIRATION DATE
	2. DATE OF INJURY OR ILLNESS	TIME OF DAY	SEND REPORT IMMEDIATELY AFTER INJURY DO NOT WAIT FOR DOCTOR'S REPORT
MAIL DUPLICATE (YELLOW) TO O.S.H.A. CASE NUMBER			

THIS FORM (IN QUADRUPPLICATE) 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.
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)

EMPLOYER	3. FIRM NAME	4. <input type="checkbox"/> New Jersey Registration No. or <input type="checkbox"/> Federal Employer identification No.	5. S.I.C. NO.	6. NO. OF EMPLOYEES
	7. MAILING ADDRESS (Please include City, Zip)	8. TELEPHONE NO. (Area Code)	9. NATURE OF BUSINESS	
	LOCATION, IF DIFFERENT FROM MAIL ADDRESS			

EMPLOYEE	10. NAME: LAST NAME - FIRST NAME MIDDLE NAME	11. SOCIAL SECURITY NO.	12. Date of Birth	13. AGE	14. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
	15. HOME ADDRESS (Number and Street, City, Zip, County)	16. OCCUPATION (Regular Job Title)		17. DEPARTMENT WHERE EMPLOYED' Mo. Day Yr	
	18. TELEPHONE NO. (Area Code)	19. WAGES Weekly \$ _____ Hourly \$ _____	20. NO. of HRS. (Regular work day)		

INJURY OR ILLNESS	21. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (Address, City, County)		
	22. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Be Specific) (Please use separate sheet if necessary)		
	23. OBJECT OR SUBSTANCE, MACHINE OR TOOL THAT DIRECTLY INJURED EMPLOYEE		
	24. NATURE OF INJURY OR ILLNESS AND PART OF BODY AFFECTED (Formal Diagnosis Not Required)		
	25. 010 EMPLOYEE DIE? <input type="checkbox"/> Yes, date _____ <input type="checkbox"/> No	26. WAS EMPLOYEE UNABLE TO WORK ON ANY DAY AFTER INJURY? <input type="checkbox"/> Yes, date last worked _____ <input type="checkbox"/> No	27. HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> Yes, date _____ <input type="checkbox"/> No
	28. NAME OF TREATING DOCTOR. IF ANY	29. DOCTOR'S ADDRESS: (Number and Street, City, Zip)	
	30. IF HOSPITALIZED. Name of Hospital	31. ADDRESS OF HOSPITAL (Number and Street, City, ZIP)	

<p>IMPORTANT NOTICE OF SPECIAL FILING RIGHTS FOR UNEMPLOYMENT INSURANCE BENEFITS</p> <p>The New Jersey Unemployment Compensation Law provides special filing rights for workers upon recovery from a work-related injury or illness.</p> <p>Eligibility for unemployment insurance benefits may be based upon wages earned prior to your disability.</p> <p>NOTE. THESE BENEFITS ARE POTENTIAL UNEMPLOYMENT INSURANCE BENEFITS. YOU SHOULD CONTACT THE DIVISION OF PROGRAMS - UNEMPLOYMENT AND DISABILITY INSURANCE FOR ADDITIONAL INFORMATION. DO NOT CONTACT THE DIVISION OF WORKERS' COMPENSATION.</p>	COMPLETED BY: (Print or Type)	TITLE:
	SIGNATURE:	DATE:

**NEW JERSEY DEPARTMENT OF LABOR
DIVISION OF WORKERS' COMPENSATION
CN 381
TRENTON, NEW JERSEY 08625-0381**

MAIL ORIGINAL (White) TO

*BLUE COPY RETAINED BY EMPLOYEE.
PINK COPY FOR PERSONNEL RECORDS.*

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

