STATE OF NEW JERSEY

EMPLOYER'S FIRST REPORT OF ACCIDENTAL INJURY OR OCCUPATIONAL ILLNESS

1. CARRIER NAME, ADDRESS	1A. 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		
	O.S.H.A. CASE NUMBER		

THIS FORM (IN QUADRUPLICATE) MUST BE COMPLETED IN THE FOLLOWING CASES ONLY:

(1) FOR EVERY ACCIDENTAL INJURY OR 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. New Jersey Registration No. or 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 Male Female
15. HOME ADDRESS (Number and Street, City, Zip, County)	16. OCCUPATION (Regular Job Title)	17. DEPARTMENT WHERE EMPLOYED		
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. DID EMPLOYEE DIE? Yes, date _____ No	26. WAS EMPLOYEE UNABLE TO WORK ON ANY DAY AFTER INJURY? Yes, date last worked _____ No	27. HAS EMPLOYEE RETURNED TO WORK? Yes, date _____ 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)	

COMPLETED BY: (Print or Type)	TITLE:
SIGNATURE:	DATE:

IMPORTANT NOTICE OF SPECIAL FILING RIGHT 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.

Eligibility for unemployment insurance benefits may be based upon wages earned prior to your disability.

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.

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

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