FIRST REPORT OF INJURY/ILLNESS FORM -- TOWNSHIP OF JACKSON

QUAL-LYNX MANAGED CARE (877) 822-9368

☐ **FOR RECORD ONLY/NO MEDICAL ATTENTION REQUESTED**
☐ **MEDICAL ATTENTION REQUESTED BY TWP/COVID EXPOSURE**
☐ **MEDICAL ATTENTION REQUESTED BY EMPLOYEE** **APPT DATE & TIME: _____** ☐ **SENT TO ER: _____**

EMPLOYEE SECTION (PART I)

Last Name: _____ **First Name: _____** **Social Security Number: _____ - _____ - _____**

Home Address: _____ Cell: ( ) _____ Email: _____

DOB: _____ **Marital Status: ☐ S ☐ M ☐ D ☐ W** **Sex: ☐ M ☐ F**

Job Title: _____ **Dept: _____** **Date of Hire: _____**

Employment Status: ☐ Full Time ☐ Part Time _____ (Less than 30) ☐ Seasonal Work Schedule: _____
Circle One: (35/40)

Date of Injury: _____ **Time of Injury: _____** **☐ AM or ☐ PM** **Bi-Weekly Wages: _____**

When this accident was first reported? _____

Give the exact location where the accident occurred: _____ Zip Code: _____

Description of the Injury and how it happened: (Note part of body injured include right or left):
_____
_____

Please list names of any witnesses: _____ **Witness Contact #: _____**

Employee Signature: _____ **Date: _____**

SUPERVISOR SECTION (PART II)

Supervisors Name: _____ **Supervisor Title: _____**

Supervisor Contact Phone Number: ( ) _____

1.	**Did you supervise this Employee on the date of the accident?**	**☐ YES**	**☐ NO**
2.	**Was the accident immediately reported?**	**☐ YES**	**☐ NO**
3.	**Was the Employee working alone or with others?**	**☐ ALONE**	**☐ WITH CREW**
4.	**Was the Employee at work and on Company Time?**	**☐ YES**	**☐ NO**
5.	**Did you physically inspect the area where the injury occurred?** **(If yes, please describe the area) _____** _____	**☐ YES**	**☐ NO**
6.	**Any unsafe conditions/unusual Hazards present?**	**☐ YES**	**☐ NO**
7.	**Evidence of Horseplay? ☐ YES ☐ NO Evidence of Drug Abuse**	**☐ YES**	**☐ NO**
8.	**Evidence of Intoxication?**	**☐ YES**	**☐ NO**
9.	**Was safety equipment provided?**	**☐ YES**	**☐ NO**
10.	**If so, describe the safety equipment: _____**		
11.	**Was safety equipment in use?**	**☐ YES**	**☐ NO**
12.	**Was immediate medical attention necessary?**	**☐ YES**	**☐ NO**
13.	**Are you satisfied that the accident/injury occurred as described above?**	**☐ YES**	**☐ NO**
14.	**Describe actions taken to prevent reoccurrences: _____** _____		

Supervisor Signature: _____ **Date: _____** ***(2/2021)***