**Employer’s First Report of Injury or Illness**

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| **Company Name/Address** | **Client ID Number** | **Phone Number** |
| **Contact Name** | **Contact email** | **Contact Phone Number** |
| **Employee Name (Last, First, MI)** | **Phone** | **Alternate Phone** |
| Job Title/Occupation  |  How long in this position | How long with company |
| Employee’s Mailing Address  | City | State  | Zip |
| Date of Injury | Time of Injury | Date Employee Reported Injury | Time Employee Started work shift  |
| Was employee doing their regular job? YES NO  | Address and Specific Location of Injury (stairs, loading dock, job site) |
| Type of Injury (Burn, bruise, laceration) | Cause of Injury (slip, trip, fall, machine, lifting) | Body Part Injured (right leg) |
| Describe in detail what the employee was doing prior to getting injured and how injury occurred |
| Was injury/accident caused by another person? YES NO | List name/phone number | Was injury caused by a motor vehicle accident? YES NO |
| List Personal Protective Equipment required  | Was employee using Personal Protective Equipment? YES NO |
| **Supervisor’s Name** | **Supervisor’s email** | **Supervisor’s Phone Number** |
| Witness Name, phone number | Witness Name, phone number |
| Doctor or Hospital Name  | Phone |
| Mailing Address | City | State  | Zip |
| Other additional information/notes:  |

***All employers are required to notify OSHA within 8 hours of a work related fatality or within 24 hours of in-patient hospitalization, amputation, or loss of an eye.***

Please contact the Questco Safety Department for assistance with reporting to OSHA 936-521-5793

Please contact the Questco Claims Department for questions on completing this form 936-521-5754

Please email completed form as soon as practical to claims@questco.net or fax it to 888-756-1920