

Employer's First Report of Injury or Illness

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	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 Safety Department for assistance with reporting to OSHA 936-521-5793

Please contact the 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 888-756-1920