First Report of Injury

TO BE COMPLETED BY EMPLOYEE OR SUPERVISOR AND RETURNED TO HR WITHIN 24 HOURS OF REPORT:
RETURN TO: HR OFFICE, 85 UNION STREET **EMAIL TO:** HR@BRUNSWICKME.ORG **FAX TO:** (207) 725-6663

REASON FOR REPORT

Lost time one or more days? ☐ Yes ☐ No		Was employee paid for ½ day or more on day of injury? ☐ Yes ☐ No	
Lost earnings but no lost time? ☐ Yes ☐ No		Was medical or health care beyond first aid received? ☐ Yes ☐ No	
Occupational Disease ? ☐ Yes ☐ No	Exposure date:		Date diagnosed as job related?
Fatality? ☐ Yes ☐ No	Date:	Correct prior report? ☐ Yes ☐ No	Date:
If none of the above are applicable, is this a ***FYI report*** to have on file only? ☐ Yes ☐ No			

EMPLOYER INFORMATION

UIAN:	0068064007		FEIN:	01-6000089			
Employer Name:	Town of Brunswick		Department:				
Address:	85 Union Street	City:	Brunswick	State:	ME	Zip:	04011
Primary Business performed by department:							
Dept. Address:		City:	Brunswick	State:	ME	Zip:	0411
Did injury occur on employer's premises? ☐ Yes ☐ No			If no, location:				

EMPLOYEE INFORMATION

First Name:		Last Name:		MI:			
Social Security #:		Gender: ☐ Male ☐ Female		Date of Birth:			
Mailing Address:		City:		State:		Zip:	
Phone:		Occupation/Job Title:					
Date of Hire:		Weekly Wage :		Does employee work for another employer? ☐ Yes ☐ No			
If yes, other employer name:		Address:					

CLAIM INFORMATION

Date of injury or illness:		Date employer notified:	
Date of incapacity:		Date employer notified:	
Time employee began work:	☐ AM ☐ PM	Time of injury:	☐ AM ☐ PM
Has employee returned to work? ☐ Yes ☐ No		If yes, date:	
Specific injury or illness:		Body part(s) affected:	
All equipment, materials, or chemicals employee was using when the event occurred:			
Activity was part of normal job duties? ☐ Yes ☐ No		Specify activity employee was doing when incident occurred:	
How injury or illness occurred:			
Did anyone witness the event? ☐ Yes ☐ No	If yes, who?		
Hospitalized overnight as inpatient? ☐ Yes ☐ No		Treated in an emergency room? ☐ Yes ☐ No	
Provider or Facility Name:		Phone:	
Provider Address:		City:	
Employee Signature:		Date:	
Supervisor Signature:		Date:	

INTERNAL USE ONLY:	Supervisor Received:		HR Received:		Filed on:

Submit