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**First Report of Accident or Injury**

**NEED TO COMPLETE THIS FORM ASAP AFTER INJURY—FAX TO ESSG AT 952-767-0740**

Last Name:		First and Other Names:	
Date of Birth:		Length of time on this assignment:	
Sex:	Social Security #:	Jobsite:	Position:
Employee's Phone: (Home):		Employee's Phone (Cell or Emergency Contact):	
Date of incident:		Time of incident: AM PM	
Name(s) of witness:		Witness Phone:	
Name of Supervisor:		Date and time notified:	

How did the incident occur? \_\_\_\_\_

**Cause of Injury/Source (please select one)**

**Type of Injury/Illness (please select one)**

No Physical Injury      Not Reported      Other specific injury: \_\_\_\_\_

**Affected Body Part (please select one)**

Insufficient info to properly identify      Not Reported      Other specific injury: \_\_\_\_\_

Please let us know what shift does EE work, Please select one:

What day of the week/weekends is the Employee scheduled to work:    Monday:    Tuesday    Wednesday    Thursday

o WAS THE EMPLOYEE PAID THE FULL DAY FOR THE DOI:    Yes    No    Friday    Saturday    Sunday

o Can Site Location Accommodate, please select one:    Yes    No

o Accommodating POSITION: \_\_\_\_\_ (EX. FILING, OFFICE ASSISTANT, ETC.)

o If you are able to accommodate, what type of work is being offered? (Please select one)

o If you are not able to Accommodate, Which date was the Employee last work day: \_\_\_\_\_

**INJURY DETAILS: (Include if it is a part of his job duties and the object that cause it ex: welding tube, hoist, packing carrots, etc.)**

<b>Description of Injury(s):</b>
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Hospital / Clinic:    Yes    No
If Yes, Name and Address of Hospital / Clinic where taken for treatment: _____
Phone: _____

Signed: _____	Print Name & Position: _____	Phone: _____
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