

**First Report of Injury**

**For Workplace Injuries**

**Demographic information**

|  |  |
| --- | --- |
| Name |  |
| Wes ID |  |
| Title/Occupation |  |
| Work Location |  |
| Address |  |
| Phone number |  |
| Email |  |
| Date of Birth |  |
| Marital Status |  |
| Dependents (# for tax purposes) |  |
| Work Schedule (Days of week) |  |

**Claim Information**

|  |  |
| --- | --- |
| Date of Injury/Exposure |  |
| Date employer notified |  |
| Location of Injury/Exposure (Best guess – building, floor, room) |  |
| Time of Injury/Exposure (note unknown if not known) |  |
| Disability begin date |  |
| First Date out of work |  |
| Return to work date |  |
| Incident Description |  |
| Were safeguards used at the time of injury |  |
| Were safe practices following at time of injury |  |

**Medical Information**

|  |  |
| --- | --- |
| Treating Provider |  |
| Treating Provider Phone |  |
| Treating Provider Address |  |

**Please complete and return to** [**benefits@wesleyan.edu**](mailto:benefits@wesleyan.edu)