Center for Workforce Inclusion
powering opportunity for older adults

8403 Colesville Road, Suite 200
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Phone: (301) 578-8900

FIRST REPORT OF INJURY

Notice of Accidental Injury or Occupational Disease

TO ENROLLEE: You must fill out and submit this report **immediately** to your Field Operations Officer after you become aware of an accident, injury or occupational disease and its relationship to your assignment.

ENROLLEE INFORMATION

Enrollee name:	Date of this report:		
Home address:	City:	State:	Zip:
Site:	Monitor:	Phone: ( )	
Address:	City:	State:	Zip:

INJURY INFORMATION

Date of injury:	Time of injury:		
Place where injury occurred:			
Address:	City:	State:	Zip:
Brief description of injury (attach additional sheets, if necessary)			

WITNESS INFORMATION

Witness name:	Phone/cell:	Email:

TREATING PHYSICIAN INFORMATION & ENROLLEE SIGNATURE

This is to notify the Center for Workforce Inclusion that I sustained an:

☐ **injury** ☐ **occupational disease**

Caused by:

Treating Physician:	Phone:		
Address:	City:	State:	Zip:

The above information is true and correct to the best of my knowledge, information, and belief.

_____ _____

Enrollee Signature **Date**

The Center for Workforce Inclusion (the Center) provides Worker's Compensation benefits in the event of a work-related injury or occupational illness or death to Enrollees that occurs while on assignment or conducting other authorized assignments. All injuries must be reported within 24 hours to The Center. In case of an emergency, the Enrollee is responsible for immediately notifying his/her Monitor and the Center's Field Operations Officer to report the incident accurately. It is essential that all information surrounding an injury or occupational illness be obtained. This enables the Field Operations Officer to report the incident accurately.