

## 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			
<p><b>This is to notify the Center for Workforce Inclusion that I sustained an:</b></p> <p style="margin-left: 20px;"> <input type="checkbox"/> injury                      <input type="checkbox"/> occupational disease         </p> <p><b>Caused by:</b></p>			
Treating Physician:	Phone:		
Address:	City:	State:	Zip:
<b>The above information is true and correct to the best of my knowledge, information, and belief.</b>			
<b>Enrollee Signature</b>			<b>Date</b>

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.