EMPLOYER'S INJURY REPORT (eFROI)

ALL FIELDS MUST BE COMPLETED

Company Name ____

Company Address ____

NYSIF Policy Number ______________________ Date of injury/Illness _______________________

Injured Employee's Information

First Name_________________________ Middle Initial ____ Last Name________________________

Social Security Number__________________ Date of Birth _________________________

Address ____

____

City __________________________________ State __________ Zip Code _____________

Gender Male______ Female______

Telephone Number ________________________

Injury or Illness Information

Date of Injury ________________________________

Employee began work at ____ am ____ pm Time of injury ____ am ____ pm

Has employee given you notice of injury/illness Yes____ No____

If yes, notice was given to

First Name ________________________ Last Name ________________________

If yes, was notice given orally or in writing or both- Orally ____ In writing ____ or both ____

Date notice provided______________________

Did you give the injured worker a "Claimant Information Packet"? Yes____ No____

If yes, on what date ______________

Accident Information

Where did injury/illness happen (FULL ADDRESS & ZIP CODE)

____

Is the accident location the same as the policy location? Yes____ No____

Was this the location where the employee normally worked? Yes____ No____

If not what was he doing there? _____________________

Employee's Supervisor First Name_____________________ Last Name ______________________

Did Supervisor see injury Happen? Yes____ No____ Unknown____

Did anyone else see the injury happen? Yes____ No____ Unknown____

If yes, give name(s) and phone number(s) ____

What was the employee doing when he/she was injured or became ill?

How did the injury/illness occur

What specific part(s) of the body was injured? (right shoulder, lower back..)

Type of injury (fracture, laceration…)

____

To your knowledge did the employee have another work related injury to the same body part or a similar illness when working for you? Yes____ No____

If yes, please provide details ____

Did the injury/illness result in the employee's death? Yes____ No____ Unknown____

Was an object involved in the injury/illness? Yes____ No____

If yes what object was involved? ____________________________

Was the injury the result of the use or operation of a licensed motor vehicle? Yes____ No____

<u>Return to Work</u>

Did employee stop work because of injury? Yes____ No____

If yes, what was the last day the employee worked? ___________________________

What was the <u>first scheduled work day they missed</u> after the accident? ___________________________

When did the employer become aware that the lost time was due to the injury/illness? _____________

Did employee lose more than or is anticipated to lose more than one week of work? Yes____ No____

Has the employee returned to work? Yes____ No____

If yes, on what date ___________________________

If yes, in what capacity? Regular Duty____ Limited duty____

If the employee has returned with limited duty what are his average gross earnings per week_______

Did the employee return to work with physical restrictions? Yes____ No____

Did the employee return to work with same employer? Yes____ No____

Employees Work Info on the date of the injury or illness

Date the employee was hired_________________
Employee's job title___________________________________ Payroll Classification Code _____________
Occupation Description_______________________________
What types of activities did the employee normally perform at work?
____
Is the injured worker the principal, partner, sole proprietor or related to the same? ___________________

Employees Payroll Information on date of the injury

Employees gross pay in an average week_________________
Did the employee receive lodging or tips in addition to pay? Yes____ No____
Employee job was Regular/Full time, Part time, Seasonal etc.? ____________________
Which days of the work did the employee usually work?
M____ TU____ W____ TH ____ FRI____ SAT____ SU____
Last day paid____________
Was the employee paid for a full day on the day of the injury/illness? Yes____ No____
Did you continue to pay the employee after the injury? (sick leave, vacation, disability, regular salary..)
Yes____ No____

Medical treatment

Did the employee already receive treatment of this injury Yes____ No____ Unknown ____
If yes what was the date of the employee's first treatment___________

Extent of medical treatment received by claimant immediately following the accident
Doctors' office____ Hospital____ Emergency Room____
Hospitalization Greater than 24 hours (admitted)_______
Who treated the employee? ____
Where was the employee treated?____
Is the employee still being treated for this injury Yes____ No____Unknown____
If yes, where? (Name & Address) ____

Please provide any additional info

Name & Telephone Number of Person who prepared this form
First Name _________________________________**Last Name**__________________________________
Phone Number ____________________**Ext.** _______ **Title**________________________