STATE OF NEW JERSEY
SCHOOLS DEVELOPMENT AUTHORITY

32 EAST FRONT STREET
P.O. BOX 991
TRENTON, NJ 08625-0991

WORKERS' COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY/ILLNESS
NJSDA FORM 1108A

INSTRUCTIONS: *The injured employee's Competent Person/Foreman-in-charge should complete this form. Both injured employee and Foreman-in-charge must sign-off. Completion of this form must be done immediately upon notification of injury and electronically sent to the following within* ***24 hours*** *of event: NJSDA assigned Field Compliance Inspector, NJSDA RMU, the OCIP insurance carrier and the CM. Original to be filed at the site by the Prime Contractor. Courtesy copy can be given to injured employee and Foreman-in-Charge, if requested.*

EMPLOYEE INFORMATION: *(Complete one report for each employee involved)*

Name: *(Last, First)*	Date of Birth: _ _ / _ _ / _ _ _ _	Gender: ❑ Male ❑ Female	Date of Hire: _ _ / _ _ / _ _ _ _
Full Address:			
Email Address:		Phone:	
Occupation:		Status: ❑ Full Time ❑ Part Time	
Employer's Name, Address, and Phone:		Nature of Business:	

INJURY INFORMATION:

Nature of Injury/Illness:		Treatment:	Name and Address of Treating Facility:
❑ Strain/Sprain	❑ Internal	❑ First-Aid	
❑ Fracture	❑ Burn/Scald	❑ E.R.	
❑ Laceration/Cut	❑ Foreign Body	❑ Dr.'s Office	
❑ Bruising	❑ Chemical Reaction	❑ Hospital Stay	Remarks:
❑ Scratch/Abrasion	❑ Allergic Reaction		
❑ Amputation	❑ Concussion		
❑ Heart Related Illness	❑ Dislocation		
❑ Other (Specify below)			

Further description of nature and extent of injury:

Body part(s) injured:

Was first aid given? ❑ YES ❑ NO	When and by whom?
Was injured transported via ambulance? ❑ YES ❑ NO	When and by whom?

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ACCIDENT INFORMATION:

Date of Injury/Illness:	Time of Incident:	Project Site:	OSHA Case #:
_ _ / _ _ / _ _ _ _	_____ ❑a.m. ❑p.m.		

What part of the employee's work day:

- ❑ Entering/Leaving Work
- ❑ During Break
- ❑ During Overtime
- ❑ During Normal Activities
- ❑ Lunch

Describe in specific detail how incident occurred *(Who was involved, when and where the incident happened, what happened, and how, include any machines, tools, materials or other important details):*

I decline medical treatment at this time:

_____ _____
Employee's signature Date

Comments:

SIGNATURES:

Prepared by: _____

Company Name: _____

Forman's Name (please print): _____

Foreman's Signature: _____

Date: _____

Employee's Name: _____

Employee's Signature: _____

Safety Manual reference:
Page 16, 9.2 First Report of Injury-Workers' Compensation.