STATE OF NEW JERSEY
SCHOOLS DEVELOPMENT AUTHORITY

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

WORKERS' COMPENSATION INCIDENT REPORTING FORM
NJSDA FORM 1108

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.*

Safety Manual reference sections are listed on last page of form.

Date of Incident (mo/day/yr): _ _ / _ _ / _ _ _ _	Time of Incident: _____ ❑a.m. ❑p.m.	Project Site:

What part of the employee's work day:

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

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

Employee name:	Date of birth: _ _ / _ _ / _ _ _ _	Home phone:	Cell phone:

Employee full address:

Employee occupation:	Employer name and length of time with employer:

How long employee was performing this operation/job:

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):*

Was the employee wearing all required PPE? ❑ YES ❑ NO	Describe PPE worn:
Were the activities part of the job? ❑ YES ❑ NO	If no, describe further:

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Were photos taken? ❑ YES ❑ NO	By whom?:

Name, address and phone number of all witnesses to the incident: *(Use separate sheet if necessary)*

Any contributing factors to incident, e.g. unsafe work conditions, unsafe acts of employee, or other:

INJURY INFORMATION:

Nature of Injury/Illness:		Treatment:	Name & 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?

I decline medical treatment at this time:

_____ _____

Employee's signature **Date**

Comments:

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CORRECTIVE ACTIONS:

I have taken the following ❑ temporary ❑ permanent immediate actions to reduce recurrence *(explain in detail):*

I recommend the following actions to prevent recurrence and anticipate completion by _ _ / _ _ / _ _ _ _ date: *(explain in detail – be specific as to what would prevent the injury, incident or damage from occurring again):*

CORRECTIVE ACTIONS TRACKING: *(All blocks must be filled in and information verifiable)*

Briefly list action(s) from above that have or will be taken to prevent a recurrence:	Assigned to Whom	Scheduled Completion Date	Actual Completion Date	Follow-up Date

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JOB HAZARD ANALYSIS REVIEW

Is there a JHA that applies to the task being performed when the injury or incident occurred? *If yes, review the JHA, answer the following questions, and attach a copy to this report.* *If no, please explain why the JHA was not required for the task.*	❑ YES ❑ NO
Were hazards sufficiently identified? *If not, please explain on separate sheet.*	❑ YES ❑ NO
Were identified controls adequate and implemented? *If not, please explain on separate sheet.*	❑ YES ❑ NO
Were the identified controls not implemented? *If not, please explain on separate sheet.*	❑ YES ❑ NO

Prepared by: _____

Company Name: _____

Forman's Name (please print): _____

Foreman's Signature: _____

Date: _____

Safety Manual reference section(s) and page(s):
Page 17, 9.3 Accident Investigation.
Page 17, 9.5 First Report of Injury-Workers' Compensation.