



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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire: __/__/____
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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:
<input type="checkbox"/> Strain/Sprain	<input type="checkbox"/> Internal	<input type="checkbox"/> First-Aid	Remarks:
<input type="checkbox"/> Fracture	<input type="checkbox"/> Burn/Scald	<input type="checkbox"/> E.R.	
<input type="checkbox"/> Laceration/Cut	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Dr.'s Office	
<input type="checkbox"/> Bruising	<input type="checkbox"/> Chemical Reaction	<input type="checkbox"/> Hospital Stay	
<input type="checkbox"/> Scratch/Abrasion	<input type="checkbox"/> Allergic Reaction		
<input type="checkbox"/> Amputation	<input type="checkbox"/> Concussion		
<input type="checkbox"/> Heart Related Illness	<input type="checkbox"/> Dislocation		
<input type="checkbox"/> 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: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Project Site:	OSHA Case #:
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What part of the employee's work day:

<input type="checkbox"/> Entering/Leaving Work	<input type="checkbox"/> During Break	<input type="checkbox"/> During Overtime
<input type="checkbox"/> During Normal Activities	<input type="checkbox"/> 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: _____

Comments: _____

Employee's signature _____ Date _____

SIGNATURES:

Prepared by: _____

Company Name: _____

Forman's Name (please print): _____

Foreman's Signature: _____

Date: _____

Employee's Name: _____

Employee's Signature: _____