PO Box 1209, Piscataway, NJ 08855
Phone: 908-222-7500 Fax: 732-465-7355

FIRST REPORT OF INJURY (FROI) / INCIDENT INVESTIGATION FORM

FAX: 732-465-7355 or EMAIL (scan into PDF format): froi@qual-lynx.com

INITIAL FILING ______ SUBSEQUENT FILING _______

EMPLOYER

1. Name of Joint Insurance Fund: **Somerset County Joint Insurance Fund**
2. Name of Fund Member: ____
3. Street address: ____
4. Employer city: ____
5. State: ____________________ Zip: __________________

EMPLOYEE/WAGE

1. FULL NAME:____
2. FULL ADDRESS: ____
   ____
3. HOME AREA CODE AND TELEPHONE #: ______________________________
4. Date of Birth: ____________________ 5. Social Security #: ____________________
6 Date of Hire: ____________________ 7. Sex: Male ____ Female ____
8. Occupation/Job Title: ____
9. Marital Status: Unmarried ____ Single/Divorced ____ Married ____ Separated ____ Unknown _____
10. Employment Status: (Please select the FIRST status that applies to the injured worker, make only ONE choice)
    Volunteer ____ Seasonal Employee ____ Regular Full Time ____ Regular Part Time _____
    Not Employed ____ Retired ____ On Strike ____ Disabled ____ Other ____
11. Wage Rate: $ ________ Per Day ____ Per Week ____ Per Month ____
12. Days worked per week: _____ 13. Did Employee receive full pay for day of injury? Yes ____ No ____
14. Did Salary continue? Yes ____ No ____

OCCURRENCE/TREATMENT

1. Time employee began work: ___________ AM/PM: ____________
2. Date of injury or illness: ______________________________
3. Time of occurrence: __________________ AM/PM: ____________
4. Last work date: ______________________
5. Date employer was notified of occurrence: ______________________
6. Date disability began: ______________________________

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7. Type of injury: ____
8. Part of body affected: ____
9. Did injury/illness/exposure occur on employers premises? Yes ____ No ____
10. Department or location where accident or illness/exposure occurred? ______________________
    ____
11. ZIP Code of injury site: ____________________
12. All equipment, materials or chemicals employee was using when accident or illness/exposure occurred:
    ____
13. Specific activity the employee was engaged in when the accident or illness/exposure occurred:
    ____
    ____
14. Work process the employee was engaged in when accident/illness/exposure occurred:
    ____
    ____
15. How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill:
    ____
    ____
16. Date returned to work: ____
17. If fatal, give date of death: ____
18. Were safeguards or safety equipment provided? Yes ____ No ____
19. Were they used? Yes ____ No ____

MEDICAL PROVIDER

1. Name of Physician or Health Care Provider: ______________________________
2. Address: ____
3. Name of Hospital or off-site treatment facility: ______________________________
4. Address: ____
5. Initial Treatment (check one):
   No Medical Treatment ____ Minor/Treatment by Employer: ____ Emergency Care: _____
   Hospitalized greater than 24 hours: _____ Future major medical/lost time anticipated: _____

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OTHER

1. Witness name: ____
2. Witness Area Code & Phone #: ____
3. Date Administrator (TPA) notified:____
4. Date Report Prepared: ____
5. Preparer's Name: ____
6. Preparer's Title: ____
7. Preparer's Area Code & Phone #: ____

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TO BE ANSWERED BY EMPLOYEE'S DIRECT SUPERVISOR

(Note this section can be completed and submitted as a supplement to your original First Report of Injury Filing. Do not hold up the initial filing of your First Report of Injury for this information. If you do choose to do a supplemental filing, please check the Supplemental filling box on the top of the form.)

1. Do you usually supervise this individual? Yes ____ No ____
   If No, Explain: ____
   ____
2. Was accident immediately reported? Yes ____ No ____
   If No, Explain: ____
   ____
3. Was employee working: Alone _________ With Crew _________
4. Did you physically inspect the area where the injury occurred? Yes ____ No ____
   If No, Explain: ____
5. Any unsafe conditions or unusually hazards present? Yes ____ No ____
   If Yes, Explain: ____
   ____
6. Was employee wearing back support? Yes ____ No ____
   If No, Explain: ____
7. Evidence of horseplay: Yes ____ No ____
   If Yes, Explain: ____
   ____
8. Evidence of intoxication Yes ____ No ____
   If Yes, Explain: ____
   ____

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9. Evidence of drug abuse Yes ____ No ____
   If Yes, Explain: ____
   ____
10. Are you satisfied that the accident/injury occurred as described above? Yes ____ No ____
    If No, Explain: ____
11. What additional training may have prevented this accident? _______________________________
    ____
12. What additional training would you like Fund's Safety Director to provide? ___________________
    ____
13. What circumstances contributed to this accident? _____________________________________
    ____
14. What actions contributed to this accident? ____
    ____
15. What changes in circumstances or actions could have prevented this accident? _______________
    ____
16. Your actions taken to minimize the chance of a recurrence? ______________________________
    ____
17. Your future plans to minimize the chance of a recurrence? _______________________________
    ____
18. Would you like to speak to any Fund Professional? Yes ____ No ____
    If Yes, please list: ____

Supervisor's Name: ____

Date: ________________

Distribution: Claims Administrator
Safety Director
Safety Delegate
Your records