



School Administrative Unit 39
1 School Street, P.O. Box 849
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EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE INFORMATION

This form must be submitted to the school nurse.

IMPORTANT: Every employer shall file this report as soon as possible after knowledge of any occupational injury or disease to an employee, but not later than five days thereafter. Notice of disability of four or more days shall be filed no later than seven days after date of injury on Supplemental Report Form No. 13 WCA. Failure to comply with any or all of the above carries a civil penalty of up to \$2,500.00. RSA 281A:53.

1. Name of injured: First Middle Initial Last			2. SS No.	3. Age:	4. Male _____ Female _____	DOB:
6. Address: Number & Street City/Town			7. State:	8. Zip Code	9. Telephone Number	
10. School assigned to:	11. Occupation when injured:	12. Was this his/her regular occupation? If not, state regular occupation:		13. Wages per hour:	14. Number of hours worked per day:	
15. Number of days worked per week:	16. Average weekly earnings:	17. Was injured hired in N.H.?	18. Date employment began:		19. Date & time of injury:	
20. Date disability began:	21. Was injured paid in full for this day?		22. Date employer was first notified:	23. Name of person notified:		
24. Building and location where accident occurred:		25. Weather conditions:		26. Surface conditions:		
27. Describe fully how accident occurred and describe what employee was doing when injured:						
28. Where there any witnesses to your injury? Who?			29. Part(s) of body injured:		30. Estimated length of disability:	
31. Has injured returned to work?		32. If so, what date?		33. At what occupation or job?		34. Returned at: Full Duty: _____ Alternative/light duty: _____
35. Equipment causing injury:			36. Were safeguards in place?		37. Was accident caused by injured's failure to use safeguards or follow regulations?	
38. Initial treatment: (check those that apply) No medical treatment: _____ Care provided on site: _____ Emergency care: _____ Hospitalized: _____						
39. Name of treating physician:			40. Name of treating medical facility:			
Employee signature (whenever possible):			Date of this report:			

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EMPLOYER INFORMATION (to be completed by the person filing the report):

Nurse or person notified of injury:		Occupation:	
Date reported to you:	Time:	Known witnesses:	Location of incident:
Part(s) of body injured:			
Did injured leave work:	When?	41. Has injured died? If so, what date?	
Recommended treatment:	Go to emergency room: _____ Go to doctors _____ No medical treatment: _____		
Explanation of incident and care administered on site:			
If you examined where the accident happened - your observations:			
Employer filing report signature:		Print name and official title:	
Administrator signature:		Print name and official title:	

WITNESS INFORMATION (to be completed by the witness):

Witness name:		Occupation:	
Building and location of incident:			
Explanation of accident:			
Equipment causing injury:	Were safeguards in place?	Was incident caused by injured's failure to use safeguards or follow regulations?	
Witness signature:		Print name and official title:	