STATE OF NEW JERSEY
EMPLOYER'S FIRST REPORT OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE

This form must be completed by the injured employee and the supervisor within 24 hours of the accident in the following cases: (1) accidental injury causing an absence from work beyond the day of injury, or (2) medical treatment by a doctor or hospital, or (3) occurrence of an occupational disease due to working (hospital admission). Immediately notify the personnel office by telephone. Retain a copy for your records and forward all other copies to your Human Resourse department per your departmental procedures.
The Human Resource department shall review the report for completeness and accuracy and file the original no later than three days after the injury occurred with the Division of Risk Management Department of Treasury

NOTE: If the employee is too severely injured to complete the report, the employee's supervisor will complete the report within the 24 hour time span and submit it to Human Resources.

ORIGINAL TO:

DEPARTMENT OF THE TREASURY
DIVISION OF RISK MANAGEMENT
PO BOX 620
TRENTON NJ 08625-0620

INCIDENT CODE DEFINITIONS

0 - First aid or other Non-recordable cases: Indicates that treatment by a licensed physician and time off work were not necessary.
1 - Medical treatment case: Indicates that treatment by a licensed physician was required, but no time off work other than day of injury for recovery.
5 - Lost work day case: Indicates that time off work, beyond day of injury, for recovery was necessary.
9 - Fatality case: Employee died from injuries received.

FOR EMPLOYEE'S SUPERVISOR USE

TABLE C - Unsafe Act or Hazardous Condition Classification

B1 -- Failure to use available personal protective equipment
C1 -- Failure to wear safe personal attire (wearing high heels, loose hair, long sleeves, loose clothing, etc.)
D -- Failure to secure or warn
E1 -- Horseplay (distracting, teasing, abusing, starting, quar - relling, practical, throwing material, showing off, etc.)
E2 -- Under the influence of alcohol, drugs or medication
F1 -- Assault from fight, hold-up, robbery, client, inmate
G -- Improper use of equipment
H -- Improper use of hand or body parts
J -- Inattention to footing or surroundings
K -- Making safety devices inoperative
L -- Operating or working at unsafe speed
M -- Taking unsafe position or posture
N -- Driving errors (by vehicle operator or public roadways.)
P -- Unsafe placing, mixing, combining (e.g. box improperly placed, piled in proper area falling on a employee).
Q -- Using unsafe equipment (e.g. equipment tagged as defective or or obviously defective).
R -- Defects of equipment, tools, materials, or work area. (Generally the opposite of the desirable and proper characteristic such as being dull when it should be sharp)
V -- Placement hazards (materials, equipment, telephone wires, etc., placed in wrong areas, aisles)
W -- Inadequately guarded
X -- Hazards of outside work environments - other than public hazards (encountered while working in or on premises not controlled by the employer and not arising from the activities of the injured or his co-employees or from the tools, materials, or equipment used in those activities)
Y -- Public hazards (encountered in public places away from employer's premises including public transportation).

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INFORMATION BELOW MUST BE COMPLETED BY THE EMPLOYEE AND THE EMPLOYEE'S SUPERVISOR IN ACCORDANCE WITH THE ATTACHED INSTRUCTIONS

Claim Number	Injured Employee Last Name	First Name	M.I.	Social Security No.	Date of Birth	Sex

Address	City	County	Zip Code	Gross Biweekly Wage	Daily Wage

Acc. Date (mm/dd/yy)	Date Employee Stopped Work	Official Workstation	Phone No. Home

Day of Week	Time	AM / PM	Date employee returned to Work	Estimate / Actual	Department	Phone No. Work
		○ AM ○ PM		○ Estimate ○ Actual		

Lost work days	Estimate / Actual	Occupation or Job Title	Division	Emergency Contact
	○ Estimate ○ Actual			

Place of accident or exposure	Agency	HR Name & Phone number

☐ Check if additional pages are attached

Describe how the accident occurred In detail

Describe the injury or illness and part of body affected

Identify witnesses on the second page

○ Witnesses ○ No witnesses

Was employee referred to authorized physician? If no, explain on other side.

○ Yes ○ No

Name of Treating Physician

Did this accident happen because of the action of others who are not co-employees or because of defective equipment? If so, complete responsible party information on other side.

○ Yes ○ No

Did the accident happen under normal workplace conditions?

○ Yes ○ No

34:15-57.4. Workers' compensation fraud: criminal and civil penalties.
A person shall be guilty of a crime of the fourth degree if the person purposely or knowingly makes, when making a claim for benefits pursuant to R.S. 34:15-1 et seq., a false or misleading statement, representation or submission concerning any fact that is material to that claim for the purpose of wrongfully obtaining benefits.

Are you or your spouse currently eligible for Medicare or Medicaid benefits? ○ Yes ○ No

Employee's Signature _____ Date _____

Information in this area to be provided by the employee's supervisor

Type of incident:
0 - First aid or other non-recordable event
1 - Medical treatment but not lost time
5 - Medical treatment and lost time
9 - Fatality case

☐ Enter number that best describes the incident.

Fatality date if applicable:

Supervisor - Did you witness the accident? ○ Yes ○ No

If yes, please describe:

Do you agree with the employee's description? ○ Yes ○ No

Supervisor Signature and Phone No. _____ Date _____

RM-2 (Revised 3/11)

Explanation for using unauthorized Physician

Staff Physician's/Nurses's remarks (for agency medical staff use)

Diagnosis

Is the injury related to the accident or work exposure? ○ Accident ○ Work Exposure

What further treatment is needed?

Date the employee is medically able to return to work (mm/dd/yyyy)

Are outside medical/pharmacy bills etc. anticipated? ○ Yes ○ No

Remarks

Date

Signature of Physician

Witnesses to Accident

Name	Address

Contact

Responsible Party Information

Name of person(s)

Identify object, machine, substance or premise

If accident caused by a vehicle, complete the following or attach copy of the RM-1 or other vehicle accident report

	EMPLOYEE'S VEHICLE	OTHER VEHICLE
Year and make of car		
License plate no.		
Owner's name		
Owner's address		
Name of Insurance co. and policy no.		
Driver's name		
Driver's address		

Was a State Vehicle Accident Report RM-1 completed and filed? ○ Yes ○ No

If no, explain

Seat Belt ○ Yes ○ No

Cellphone ○ Yes ○ No

State of New Jersey
DEPARTMENT OF THE TREASURY
DIVISION OF RISK MANAGEMENT
P. O. BOX 620
TRENTON, NEW JERSEY 08625-0620
TELEPHONE: (609) 292-1850
FACSIMILE: (609) 292-2437

PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

ELIZABETH MAHER MUOIO
State Treasurer

MICHAEL D. SMITH
Acting Director

Outside Employment Form

Name: _____ Claim # _____

Address: _____

Current Job Title and Duties with State of NJ: _____

_____

_____

Current work schedule and hours: _____

Outside employment: Are you currently engaged in or planning to engage in any business, trade, profession and/or part time or full time employment (includes paid or unpaid):

(If yes, provide the required information)

Name(s) of Employers or Business(es): _____

Job title and description of duties: _____

Hours worked per week: _____

If you obtain additional employment at any time during treatment for your Workers' Compensation claim you must contact your claims investigator to disclose the name of the employer and job responsibilities.

Signature: _____ **Date: _____**