Highland Claim Services, Inc.
PO Box 222, McAfee, NJ 07428-0222
973-459-4250 (Phone) 973-679-8796 (Fax)

FIRST REPORT OF INJURY (FROI)

INITIAL FILING_______ SUBSEQUENT FILING ________

Injured Employee: ____ Date of injury or illness: __________________

EMPLOYER

SCJIF Employer/Insured: ____

Street address: ____

Employer city: ____

State: _____________________________ Zip: ___________________________

EMPLOYEE/WAGE

1. Full Name:____
2. Full Address: ____

   ____

3. Home phone #: _______________________________ Cell phone #: _____________________________
4. Email: ____
5. 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 Hour ________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

1. Time employee began work: ____________ AM/PM

2. Time of occurrence: ___________________ AM/PM
3. Last date worked: ______________________
4. Date employer was notified of occurrence: ______________________

5. Date disability began: ____
6. Type of injury: ____
7. Part of body affected: ____
8. Did injury/illness/exposure occur on employer's premises? Yes_____No ______

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Injured Employee: ___________________________

Injury Date: ________________________________

9. Department and/or location where accident or illness/exposure occurred? ___________________
   ____

10. ZIP Code of injury location: _________________
11. All equipment, materials or chemicals employee was using when accident or illness/exposure occurred:
    ____

12. Specific activity the employee was engaged in when the accident or illness/exposure occurred:
    ____
13. Work process the employee was engaged in when accident/illness/exposure occurred:
    ____
14. 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:
    ____
    ____
15. Date returned to work: ____
16. If fatal, give date of death: ____
17. Were safeguards or safety equipment provided? Yes_____No ______
18. Were they used? Yes_____No ______

MEDICAL TREATMENT

19. Initial Treatment (check one):
    No Medical Treatment _____ Minor/Treatment by Employer: _____ Emergency Care: ______

    Hospitalized greater than 24 hours:_______Future major medical/lost time anticipated: ______
20. Name of Physician or Health Care Provider: ____
21. Address: ____
22. Name of Hospital or off-site treatment facility: ____
23. Address: ____

OTHER

1. Direct Supervisor name: _____________________________________ Phone: _______________________
2. Witness name: ____
3. Witness Phone #: ____
4. Date Administrator (TPA) notified:____
5. Date Report Prepared: ____
6. Preparer's Name: ____
7. Preparer's Title: ____
8. Preparer's Phone #:____

Distribution: Guardian PECS, First MCO, Insured

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SUPERVISOR REPORT – WORKERS COMPENSATION CLAIM

To be completed by direct supervisor

Injured Employee: ______________________ Injury date/time ______________

Supervisor Name: ______________________ Phone #: ______________

Employer/Insured: ______________________ Email: ______________

Address: ______________________

Phone: ______________

1. Employee Job Title: ______________ Department: ______________
2. Location of Occurrence: ______________
3. Injured body parts: ______________
4. How was employee injured: ______________
5. Do you usually supervise this individual? Yes ○ No ○ If not explain: ______________
6. Was accident immediately reported? Yes ○ No ○ If not explain: ______________
7. Was employee working: Alone ○ With Crew ○
8. Did you physically inspect the area where the injury occurred? Yes ○ No ○ Is video available? Yes ○ No ○
   If not, explain: ______________
   Explain findings: ______________
9. Any unsafe conditions/hazards present? Yes ○ No ○ Explain: ______________
10. Was employee wearing back support? Yes ○ No ○ Explain: ______________
11. Evidence of horseplay: Yes ○ No ○ If Yes, Explain: ______________
12. Evidence of intoxication Yes ○ No ○ If yes, Explain: ______________
13. Evidence of drug abuse Yes ○ No ○ If Yes, Explain: ______________
14. Are you satisfied that the accident/injury occurred as described above? Yes ○ No ○
    If Not, Explain: ______________
15. What additional training may have prevented this accident? ______________
16. What additional training would you like Fund's Safety Director to provide? ______________
17. What circumstances contributed to this accident? ______________
18. What actions contributed to this accident? ______________
19. What changes in circumstances or actions could have prevented this accident? ______________
20. Your actions taken to minimize the chance of a recurrence? ______________
21. Your future plans to minimize the chance of a recurrence? ______________
22. Would you like to speak to any Fund Professional? Yes ○ No ○
    If Yes, please list: ______________

SIGNATURE: ______________ **DATE:** ______________

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EMPLOYEE ACCIDENT REPORT

NAME	INJURY DATE & TIME	EMPLOYER:	
HOME ADDRESS:	HOME PHONE # CELL PHONE #	DIRECT SUPERVISOR NAME & PHONE	
JOB TITLE:	DOMINANT HAND:	DATE OF HIRE:	EMAIL:

Describe in detail what you were doing and how you were injured:
Describe all body parts injured; and your current complaints
Provide exact location of incident. Is location on employer premises: Yes No
Have you seen any doctors for this injury? If so, name, phone number and details of visit(s)
Have you ever injured this part of your body before: Yes No If yes, please provide the name and address of the treating physician(s). List any medications you are or were taking for this condition/injury?
Have you been treated by a chiropractor? Yes___ No ___ If yes, please provide the name and address of the chiropractor(s):
Have you filed any workers' compensation claims(s) in the past? Yes________ No ________ Have you ever been injured in any motor vehicle collisions? Yes_________No _______ If yes , please provide the details:
Primary care physician: Name, address and phone number
Do you have any other employment? Yes___ No___ If yes, please list the names and addresses of these employers:
Do you currently (in the past 12 months) participate in any athletic, recreational, or sporting activities? Yes___ No___ If yes, please list the activities you participate in:
To whom did you first report the injury and when?
Were there any witnesses to your injury? If so, Name of witness & contact information

Use reverse side for any additional details.

I CERTIFY THAT THE ABOVE STATEMENTS MADE BY ME ARE TRUE AND CORRECT. I AM AWARE THAT IF ANY OF THE STATEMENTS ARE WILLFULLY FALSE, I MAY BE SUBJECT TO DISCIPLINARY ACTION BY MY EMPLOYER.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician, hospital or other person or institution to permit Highland Claims Services, Inc. or its representative to examine, make, or be furnished with any information concerning illness or injury sustained by me including treatment, consultations, medical history, hospital records, prescriptions, diagnosis or findings. A photo static or scanned copy of this authorization shall be considered as valid as the original.

EMPLOYEE SIGNATURE	SOCIAL SECURITY #	DATE