First Notice of Injury Form

Please fax this form to Choice Employer Solutions at 813-643-4441 or Email wcclaims@choicehr.com within 24 hours after a workplace injury.

This form is for reporting purposes only and does not authorize medical treatment.

Injured Employee Information

Client Name	______________	Today's Date	______________
Injured Employee Name	______________	Employee SSN	______________
Date of Accident	______________	Time of Accident	______________ am ☐ pm ☐
Employee Address	______________	Phone Number	______________
City, State, Zip	______________	Date of Birth	______________
Occupation	______________	Date of Hire	______________

Accident Information (To be completed by employee supervisor)

Supervisor Name (printed) ______________ Supervisor Contact Phone Number: ______________

Employee's Description of Accident: ______________________________

____

____

Part of Body Injured (including left or right side) ______________________________

Injury or Illness that occurred? ______________________________

Did Accident Occur on Premises? ☐ Yes ☐ No If No, where? ______________________________

Equipment or devices damaged? ☐ Yes ☐ No If Yes, what? ______________________________

Were there any witnesses? ☐ Yes ☐ No List names ______________________________

Do you agree with the description of the accident? ☐ Yes ☐ No If no, reason?

____

Was employee sent for drug test? ☐ Yes ☐ No Facility Name, address and phone?

____

Facility Name, address and phone where employee sought treatment?

____

Do you know of any other prior accidents or pre-existing conditions that may have been a factor in this accident? ☐ Yes ☐ No

If Yes, explain ______________________________

____

Has employee returned to work? ☐ Yes ☐ No If yes, what date? / /

Last date employee worked? ______/______/ Last date employee was paid for? / /____

Will you continue to pay wages instead of Worker's Comp? ☐ Yes ☐ No If yes, through when? ____ __/ /___

Employee's current wage? $________ per ________ Average Hours per day? ______________

Average hours per week? ______________ Average number of days per week? ______________

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information commits fraud, punishable as provided in s. 817.234. Section 441.105(7), F.S.

I have reviewed, understand and acknowledge the above statement.

______________________________ ______________

Employee Signature (If available) Date

______________________________ ______________

Employer Signature Contact Number Date