CONFIDENTIAL

The GW Medical Faculty Associates

FOR FIRST REPORT OF INJURY FORM

EMPLOYER INFO:
Medical Faculty Associates
2150 Pennsylvania Ave NW
Washington, DC 20037
(202) 741-2344
Esther Ogbue, RN, MScN, COHN- OCCUPATIONAL HEALTH OFFICE

Health Policy# 72WNS37402 **Acct#** 46477 **Employer ID:** 52-2220700

Location Code: Date of Incident/Injury

EMPLOYEE INFORMATION

Name: Social Security #:

Home Phone Work Phone

Address City/State

Zip Code Date of Birth

◯ Male
◯ Female

The following information is mandated by the U.S. Department of Labor Bureau of Labor Statistics:
Race/Ethnicity:

Marital Status Number of Dependents

Department Job Title:

Employment Status Date of Hire

Reg. Work Schedule Hours (e.g. 8am-5pm)

Hours worked per day

Days worked per week

Time Started Day of Injury

Was Full Pay Received the Day of Injury? ◯ Yes ◯ No

Did Salary Continue? ◯ Yes ◯ No

ACCIDENT INFORMATION

Date of Incident

Time of Incident

Date Employer Notified

Supervisor Name

Witnesses

Last Date Worked

Date Returned to Work

Date Disability Began (if applicable)

Nature of Injury

Body Part Injured

Cause of the Injury

Were Safeguards or Safety Equipment provided and in use?

◯ Yes ◯ No ◯ N/A

Describe the Accident- How did it occur?

Describe the Object that Caused the Injury

Describe the Employee's Activity at the Time of Injury

Treatment for Injury?

If ER or Urgent Care, hospitalized overnight?

◯ Yes ◯ No

If Yes, Name and Phone Number of Treating Provider

For Needlestick or Sharps Injury You MUST Complete the Following Information

Type of Needle/ Sharp

- ☐ Suture
- ☐ Butterfly
- ☐ Injection Needle
- ☐ Detachable Needle
- ☐ Scalpel
- ☐ Surgical Instrument

Safety Device on Needle/Sharp?

- ◯ Yes
- ◯ No
- ◯ N/A

If Safety Needle/Sharp, was the Safety Device Engaged After Use?

- ◯ Yes
- ◯ No

If No, please describe why (i.e. pt moved, unsure how safety device works, improper set-up or technique, etc.)

Claim Number Assigned

SE Worker's Compensation Office
1-877-673-9222

Hartford Intake Representative

Hartford Claims Services
1-800-327-3636

Claims to be sent to:
The Hartford Medical Billing Center
PO Box 14170
Lexington, KY 40512