PMA COMPANIES

First Injury Report

Print Form

COMPLETE THIS FORM ELECTRONICALLY. PRINT USING THE PRINT BUTTON ABOVE. HAVE SUPERVISOR SIGN AND SUBMIT HARD COPY TO BUSINESS OFFICE, ATTN: INSURANCE DEPT.

Employee Involved | Job Title | Date of Hire

Employee Social Security | Date of Birth | ◯ Male ◯ Female

Employee Address

City | State | Zip

Department | Employee Phone# (include zip)

Supervisor | Supervisor's Phone # (include zip)

Severity of Injury

Is Employee losing time from work? ◯ Yes ◯ No ◯ Unknown

Is Employee on restricted duty? ◯ Yes ◯ No ◯ Unknown

Date lost time began:

Date restricted duty began:

Type of Injury

- ☐ Fall from elevation
- ☐ Fall on same level
- ☐ Struck against
- ☐ Struck by
- ☐ Puncture
- ☐ Caught in, under or between
- ☐ Rubbed or abraded
- ☐ Bodily reaction
- ☐ Overexertion
- ☐ Contact with electrical current
- ☐ Contact w/ temp. extremes
- ☐ Contact w/ other
- ☐ Public transportation accident
- ☐ Motor vehicle accident
- ☐ Slip
- ☐ Exposed to bodily fluids
- ☐ Insect/animal contact
- ☐ Unknown
- ☐ Other

Nature of Injury

- ☐ Abrasion
- ☐ Amputation
- ☐ Burn
- ☐ Contusion
- ☐ Crushed
- ☐ Foreign Body
- ☐ Fracture
- ☐ Inhalation
- ☐ Laceration
- ☐ Puncture
- ☐ Rash
- ☐ Strain
- ☐ Sprain
- ☐ Skin contact
- ☐ Rep. Motion
- ☐ Illness/Infection
- ☐ Insect/Animal bite
- ☐ Other (describe)

Body Part Injured

- ☐ Right
- ☐ Left
- ☐ Arm
- ☐ Shoulder
- ☐ Back
- ☐ Eye
- ☐ Face
- ☐ Finger
- ☐ Foot/feet
- ☐ Knee
- ☐ Groin
- ☐ Hand
- ☐ Head
- ☐ Internal Organs
- ☐ Leg
- ☐ Knee
- ☐ Multiple
- ☐ Neck
- ☐ Torso
- ☐ Trunk
- ☐ Wrist
- ☐ Other(describe)

Comments

Date of Accident | Time of Accident | Time Work Began

Date Reported to supervisor

How did accident occur?

Where did accident occur? (include address)

Cause of accident

Witnesses

Name		Dept./Address		Phone #	
Name		Dept./Address		Phone #	
Name		Dept./Address		Phone #	

Recommendations to prevent a recurrence:	
What action has been taken/planned to date?	

Dept. Date

Supervisor Signature: