

**DIOCESE OF MANCHESTER
EMPLOYER'S ACCIDENT REPORT
FIRST REPORT OF
OCCUPATIONAL ACCIDENT, INJURY, OR DISEASE**

TO BE COMPLETED BY THE EMPLOYER

DIRECTIONS: 1. **IMMEDIATELY** fax report to; Office of Risk Management (603) 669-0377
2. Mail original report to Office of Risk Management PO Box 310 Manchester, NH 03105 Tel: (603) 669-3100
PLEASE TYPE OR PRINT LEGIBLY

EMPLOYEE ACCIDENT INSTITUTION

Name _____
Last First MI No. Street

Male ___ Female ___ Date of Birth _____ Age _____
City State Zip

Soc. Sec. No. _____ Home Telephone _____

Date Employment Began _____ Job Title _____ Was this employee's usual job? Yes ___ No ___

LOCATION WHERE ACCIDENT OCCURRED _____

DAY/DATE/TIME OF INJURY _____ Was employee paid in full for this day? Yes ___ No ___

Wages per Hour _____ Hrs Worked per Day _____ Days Worked per Week _____ Average Weekly Wage/Salary _____

Date Disability Began _____ Expected Length of Disability _____

Is this employee temporary/leased? ___ Yes ___ No ___ If yes, provide client's business name/address _____

Date Supervisor Learned of Injury _____ Name of Supervisor _____

Nature of Injury/Illness _____ Part of the Body Affected _____

Describe FULLY How Accident Occurred including the Events Leading to the Accident : _____

Name of Witness _____ Phone _____

Did employee receive treatment at work? Yes ___ No ___ If yes, describe _____

Did the employee Leave Work? Yes ___ No ___ If yes, when? _____ Possible Length of Disability _____

Has the employee Returned to Work? Yes ___ No ___ If yes, when? _____ Regular Duty ___ Light Duty ___

Did employee seek treatment? Yes ___ No ___ If yes, When? _____

Where? _____ Physician Name _____

Parish/School/Institution _____ Phone _____ Email _____

No. Street City State Zip

Federal ID _____ Number of Employees: Full Time _____ Part Time _____

Is there a Written Safety Program **in force**? Yes ___ No ___ Is there and **active** Safety Committee? Yes ___ No ___

Describe any unsafe act, physical conditions, or other factors that MAY have contributed to this accident _____

Report Completed by _____ Title _____ Date _____