Arrow First Report of Injury Form for Name:_____

Please complete this form in addition to the First Report of Injury or Illness.

Is this a lost-time claim? ☐ Yes ☐ No

(Claim is lost time if there is a loss of more than three scheduled workdays due to the injury.)

Severe Injury: ☐ Yes ☐ No

Name of Employer Representative Notified: _____

C. List any Specific Comments:

Safety Equipment Provided

_____

_____

_____

Safety Equipment Used

_____

_____

_____

Possible Drug/Alcohol Involved

_____

_____

_____

Medical Provider Information; where was your employee treated?

_____

_____

_____

D. Location and Treatment:

☐ No Medical Treatment ☐ Treated by Employer ☐ 911 Called Walk-In Clinic (location):

_____

Emergency Room (location)

_____

Hospitalized more than 24 hours / Overnight (location)

_____

E. Return to Work Information:

Has injured worker returned to work? ☐ Yes ☐ No

Date Returned to Work:_____ Estimated Return: _____