



# First Report of Injury Form

## Unified Fire Authority



Employee Name:

Last 4 of SSN:

Employee Address:

City, State, ZIP:

Home Phone:

Cell Phone:

Date of Birth:

Date of Hire:

Station #/Platoon:

Employment Status (Check One):      Full Time

Part-time / Seasonal

Supervisor's Name/Phone#:

Date/Time of Injury/Exposure:

Witness Name & Phone #:

Address of Injury (Physical Location):

Description of Accident, Injury or Exposure:

NFPA Required Information: Choose One:

1. Responding to or returning from incident
2. At Fire Ground
3. At non-fire Emergency
4. Training
5. Other on-duty

NFPA Required Information: Classified as, Choose One:

- |                               |                                |
|-------------------------------|--------------------------------|
| 1. Burns                      | 6. Dislocation/Fracture        |
| 2. Smoke or Gas Inhalation    | 7. Heart Attack/Stroke         |
| 3. Other Respiratory Distress | 8. Strain/Sprain/Muscular Pain |
| 4. Burn/Smoke Inhalation      | 9. Thermal/Heat/Cold Injury    |
| 5. Wound/Cut/Bleeding/Bruise  | 10. Other                      |

Body Part(s) Involved in Injury or Exposure(s):

Initial Treatment-Check One:

- |  |  |
|--|--|
| 1. No Medical Treatment                  | 2. First Aid Only                              |
| 3. Minor Treatment by clinic or hospital | 4. Transported by Ambulance for Emergency Care |

Hospital/Clinic Treatment was Received:      N/A

Employee Signature:

Date:

Supervisor Signature:

Date:

BC/Next Supervisor Signature

Date: