

First Report of Injury or Illness



The First Report of Injury form must be completed by the supervisor and e-mailed to safety.environmental@bangormaine.gov within 24 hours of the injury or illness. All sections must be completed before submission. It is recommended that the injured employee be present when completing the form to assist with the details of the accident. If the severity of the injury or illness requires immediate medical care (e.g. emergency room or transported by ambulance), notify Safety and Environmental Management immediately.

Employee Information

1. Employee Name: First Name MI Last Name			2. Date of Hire: mm dd yyyy		
3. Home Address: No./Street City St Zip				4. Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
5. Social Security #:			6. Employee's Phone Number:		
7. Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Other (i.e. Seasonal, Temporary, Election, Volunteer, etc...)			8. Date of Birth: mm dd yyyy		
9. Job Title:			10. Department:		
11. Supervisor Name:			12. Supervisor Phone:		
13. Does the employee work for another employer? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>** If yes, please complete 13a. Leave blank if employee is unavailable to answer this question</i>		13a. Secondary Employer Information: Name/Contact Phone No./Street City St Zip			

Incident Information

14. Date of Injury or Illness: mm dd yyyy		15. Time of Injury or Illness: <input type="checkbox"/> AM <input type="checkbox"/> PM		16. Time employee began work: <input type="checkbox"/> AM <input type="checkbox"/> PM	
17. Was the employee doing his/her regular job at the time of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		17a. If no, explain:			
18. Location where injury or illness occurred:					
19. List all equipment, materials or chemicals the employee was using when the incident occurred (e.g. drill press, pool chemicals, front-end loader, etc...):					

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20. Specify activity the employee was engaging in when the event occurred (e.g. Shoveling hot top, teaching class, loading dump truck, etc...):	
21. What body part(s) were affected (e.g. left wrist, right knee, lower back, etc...): <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	
22. Describe the specific injury/illness (e.g. strain, laceration, bite, etc...):	
23. Describe in full how the injury/illness occurred:	
24. Were there any witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list witnesses.	24a. 24b.
25. What can be done to prevent this from happening again in the future?	
26. Did the injured employee seek medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> St. Joe's Workwell – 10-day Occupational Health Provider <input type="checkbox"/> Emergency Room	
<input type="checkbox"/> Penobscot Community Health Care Walk-in Clinic <input type="checkbox"/> Other: _____	