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:

Station #/Platoon: Date of Hire:

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:

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:

Employee Signature: Date:

Supervisor Signature: Date:

Email completed form to your immediate supervisor, HR Division and Health/Safety Officer or CLICK HERE to email to HR/Safety