



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:

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:

Employee Signature:

Date:

Supervisor Signature:

Date: