TOWN OF WEARE
FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

IMPORTANT; *This form is a tool to gather information prior to the filing of a Worker's Compensation Incident. Once this form is completed, it must be returned to the Weare Town Offices for filing.*

PLEASE TYPE OR PRINT. ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED.

EMPLOYEE INFORMATION

1. Name of injured: First / Middle Initial / Last	2. DOB:	3. Age:	4. Male ◯ Female ◯	5. SS No.:

6. Address: No. & St. / City/Town	7. State:	8. Zip Code:	9. Tel. No.:

10. Is there on file a N.H. Youth Employment Certificate?:	11. Occupation when injured:	12. Was this his/her regular occupation? If not, state regular occupation:	13. Wages per hr.:	14. No. hrs. worked per day:

15. No. days worked per week:	16. Average Weekly Earnings:	17. Was injured hired in N.H.?	18. Date employment began:	19. Date & Time of Injury:

20. Date disability began:	21. Was injured paid in full for this day?	22. Date supervisor/employer was first notified:	23. Name of Person notified:	24. Location/Jobsite where accident occured:

25. Describe fully how accident occurred and describe what employee was doing when injured:

26. Name of witness(es):	27. Part(s) of body injured:	28. Estimated length of disability:

29. Has injured returned to work?	30. If so, what date?	31. At what occupation or job?	32. Returned at: Full Duty: ◯ Alternative/Light Duty: ◯

33. Equipment causing injury:	34. Were safeguards in place?	35. Was accident caused by injured's failure to use safeguards or follow regulations?

36. Initial Treatment: (check those that apply) No medical treatment: ☐ Care provide by Employer only (on-site): ☐ Emergency care: ☐ Hospitalized: ☐
Other: (Outpatient): ☐ (Clinic): ☐ (Office Visit): ☐ (Other-explain): ☐

37. Name of treating physician: / Name of treating hospital:	38. Has injured died? If so, what date?

EMPLOYER INFORMATION

39. Legal Business Name and/or D/B/A or Leasing Company Name:	40. Employers Federal ID:	41. If leased or temporary worker, client's business name:
Town of Weare	02-6000956	

42. Business Address of No. 39 above:	43. City/State:	44. Zip:
15 Flanders Memorial Road	Weare NH	03281

45. Telephone Number:	46. Insurance Co. (**not agent**) or Self Insured Group:	47. Managed Care Program? Y or N. If yes, name Provider:
(603) 529-7575	PRIMEX	

48. No. of Employees: Full-time:	Part-time:	49. Is there a Written Safety Program **in force**?	50. Is there an **active** Safety Committee?
44	30		Yes

51. Business SIC Code	52. Type or Nature of Business in N.H.:	53. If report sent by Insurance Agency, state name:
91990404	Municipality	

54. Employer Signature:	55. Printed/Typed Name and Official Title:

56. Employee Signature (**whenever** possible):	57. Date of this report: