Medlogix

First Report of Injury (FROI) Report Form
Please fax to: 609-631-7736 or Email: FROImailbox@medlogix.com

Caller Information:

CALLER'S NAME AND TITLE:				PHONE NUMBER:
WILL YOU BE THE CONTACT PERSON? IF NO, WHO WILL BE CONTACT PERSON?		YES NO	CONTACT PERSON'S NAME:	CONTACT PHONE NUMBER:

Injury

DID THE INJURY OCCUR MORE THAN 3 DAYS AGO? (IF YES, WHY THE DELAY IN REPORTING)		YES		NO
REASON FOR DELAY:				

Injured Worker Information

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOC. SEC. NUMBER	DATE OF HIRE

ADDRESS (INCLUDE ZIP)	SEX		MARITAL STATUS
		M	MARRIED
	MALE	U	SINGLE/DIVORCED UNMARRIED
	FEMALE	S	SEPARATED
	UNKNOWN	K	UNKNOWN

HOME PHONE NUMBER:	CELL PHONE NUMBER	# OF DEPENDENTS		EMPLOYMENT STATUS		OCCUPATION/TITLE

RATE PER		HR WK	DAYS WORKED/WEEK	HOURS WORKED/DAY	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		YES NO		YES NO

Employer

EMPLOYER NAME:	
ADDRESS: (Include ZIP)	
PHONE NUMBER:	FEDERAL TAX ID:

Employee Work Information

TIME EMPLOYEE BEGAN WORK		AM PM	WHAT ARE HOURS THEIR NORMALLY SCHEDULED SHIFT?		WHAT DATE DID EMPLOYEE NOTIFY SOMEONE OF THEIR INJURY?	

WHO WAS IT REPORTED TO? (NAME & TITLE)		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		YES NO	WERE THEY USED?		YES NO

IS THERE A REASON FOR THIS CLAIM TO BE PLACED UNDER INVESTIGATION? (If yes, list reason)

Occurrence/Injury

DATE OF INJURY		TIME OF INJURY		AM PM	DID THE INJURY OCCUR ON THE EMPLOYER'S PREMISE'S?		YES NO

LOCATION/DEPARTMENT WHERE INJURY OCCURRED:

DESCRIBE HOW INJURY OCCURRED:

WHAT IS THE NATURE OF INJURY AND TO WHAT BODY PART?		Body Part		Left Right		Upper Lower

WAS THE INJURY FATAL?		YES NO	DATE OF DEATH		DID EMPLOYEE SEEK TREATMENT?		YES NO	

WHAT WAS THE MODE OF TRANSPORTATION TO THE PROVIDER?

HAS INJURED WORKER RETURNED TO WORK?		YES NO	IF YES, RETURNED TO WORK DATE		IF NO, LAST DATE WORKED:	

Provider Name Address and Phone No.:	Was Injured Worker hospitalized for more than 24 hours: ☐ YES ☐ NO

Witness

Witness Name and Phone #