First Aid Form

* required information

Initial Information:	
* NYSIF Policy Number (must be active on Date of Accident being reported)	
* Date of Injury/Illness	
* Does Injured Worked have a SSN? If yes, SSN is required.	
* First and Last Name of Injured Worker	
* Date of Birth of Injured Worker	
* Address of Injured Worker	
* First Report of Injury Preparer (Employer, Third Party or NYSIF Employee)	
* eFROI Initiator e-mail address	
Broker/Safety Group Manager's email (optional)	
Policyholder Information:	
* Policy Entity	
* Policy Location	
* Industry Type	
* Have you given the employee a Claimant Information Packet? If yes, date is required.	
Employee Information:	
* Gender	
Time employee began work	
Time of injury	
* Did employee give notice of accident/illness? If yes, must indicate when and to whom? Was it given orally, in writing or both?	
Accident Information:	
* Where did the accident/illness happen?	
* Is the accident location the same as the policy location? If no, must select Accident Premises Code (Lessee or Other)	
* Accident County	
* Was this the location where the employee normally worked? If no, must indicate why the employee was there?	
First and Last Name of Employee's Supervisor	
* Did supervisor see injury happen?	
* Did anyone else see injury happen? If yes, need names and contact info.	
* What was employee doing when he/she was injured or became ill?	
* How did the injury/illness occur?	
Injury Information:	
* Body part(s) injured (up to six body parts may be selected)	
* Nature of Injury (such as "Laceration" or "Fracture")	
* Type of Loss	
* Cause of Injury	
* To your knowledge, did the employee have another work-related injury to the same body part or similar illness while working for you?	
* Did the injury/illness result in the employee's death?	
* Was an object involved in the injury/illness? If yes, what object?	

* Was the injury the result of the use or operation of a motor vehicle? If yes, was it employee's vehicle, employer's vehicle or other vehicle?	
Medical Treatment Information:	
* Did the employee receive treatment for this injury/illness? If no, skip the rest of the questions in this section.	
* What was the date of the employee's first treatment?	
* What was the extent of medical treatment received by claimant immediately following the accident?	
* Who treated the employee?	
* Where was the employee treated?	
* Is the employee still being treated?	
Name and address of treating medical provider	
Employment Information:	
* Did employee stop working due to his or her injury/illness? If no, skip down to "Date of Hire".	
* What was employee's last date worked?	
* Did employee lose more than or is anticipated to lose more than one week of work?	
* Has employee returned to work? If yes, on what date?	
* If employee returned to work, was it regular duty or limited duty?	
* If employee returned to work, was it with restrictions?	
* If employee returned to work, was it for the same employer?	
Date of Hire	
Job Title	
* Occupation Description	
* Manual Classification Code (if not a NYS Agency)	
What types of activities did claimant normally perform at work?	
* Employee's gross pay in an average week	
* Did employee receive lodging or tips in addition to pay? If yes, describe.	
* Employee's job was… (choose Full Time, Part Time, Seasonal, etc.)	
* Which days of the week did the employee usually work?	
Last Day Paid	
* Was the employee paid for a full day on the day of the injury/illness?	
* Did you continue to pay the employee after the injury/illness?	
Additional Information:	
Please provide any additional information. (This information is provided to NYSIF only)	
* FROI submitter type (Employer, Third Party or NYSIF Employee)	
* FROI submitter e-mail address	
* First and last name, and telephone number, of person who provided information necessary to prepare this form	