# TraylorPro LLC 225-709-0590

## FIRST REPORT OF INJURY

This report must be filled out completely and accurately. You may attach additional sheets if necessary.

| | |
|---|---|
| Name of injured: | Date of injury: |
| Address of injured: | Time of injury: ☐ AM ☐ PM |
| Last day employee worked:<br>(If no time was lost, state "same") | Where injury happened: |
| Date returned to work: | |

| **WHAT HAPPENED** | Describe what injured was doing at the time of the accident: what happened, who was involved, nature of injury, equipment involved, part of body affected. |
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| Weather Conditions (if applicable): | |
| **MEDICAL CARE** | List nature and extent of known injuries, be as specific as possible. |
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| Were medical services rendered at the time of the accident? ☐ YES ☐ NO | |
| If yes, name of doctor and medical facility: | |
| Address: | Phone Number: |
| Emergency Room Visit: ☐ YES ☐ NO | Overnight In-Patient: ☐ YES ☐ NO |

| **WITNESS INFORMATION** | If statements were taken, attach pages to this form. | |
|---|---|---|
| Name: | Address: | Phone: |
| 1. | | |
| 2. | | |
| 3. | | |

| **UNSAFE ACTS OR CONDITIONS** | |
|---|---|
| Did the employee do something incorrectly? ☐ YES ☐ NO | |
| Were there unsafe working conditions or improper working equipment involved? ☐ YES ☐ NO | |
| Explanation of "yes" answers: | |
| | |
| | |

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|---|---|---|
| Report Prepared By: | | Date: |
| Signature of Injured Employee: | | Date: |

**Please fax back to TraylorPro at 225-709-0701**