

# SCIBAL ASSOCIATES

PO Box 500 ▪ Somers Point, NJ 08244-0500  
Phone: 609.653.8400 ▪ Fax: 609.926.9270

250D Corporate Court \_ South Plainfield, NJ 07080  
Phone: 908-222-7500 \_ Fax: 908-222-2299

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INITIAL FILING \_

SUBSEQUENT FILING \_

## **FIRST REPORT OF INJURY (FROI) – FOR E-MAIL SUBMISSIONS**

### **Instructions for form completion and e-mailing:**

- \_ Save the master form with a new file name (File, Save As)
- \_ Use TAB key to move through answer fields
- \_ All information must be completed for each claim submitted
- \_ When finished, save file again.
- \_ E-mail form to: [froi@sciadvantage.com](mailto:froi@sciadvantage.com)

### **EMPLOYER**

1. Name of Joint Insurance Fund:
2. Name of Fund Member:
3. Street address:
4. Employer city:
5. State:
6. Zip:

### **EMPLOYEE/WAGE**

1. Last name:
2. First name:
3. Middle initial:
4. Street address:
5. City:
6. State:
7. Zip:
8. Home area code & telephone #:
9. Date of birth:
10. Social security #:
11. Date of hire:
12. State of hire:
13. Sex: male female
14. Occupation/job title:
15. Marital status:  
 Unmarried  Single/Divorced  Married  Separated  Unknown
16. Employment status: (Please select the FIRST status that applies to the injured worker, make only ONE selection)
  - 1  Volunteer Worker
  - 2  Seasonal Employee
  - 3  Regular Full Time Employee
  - 4  Regular Part Time Employee
  - 5  Not Employed

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- 6  Retired
- 7  On Strike
- 8  Disabled
- 9  Other

17. Wage rate: \$             per day    per week    per month
18. Days worked per week:
19. Did employee receive full pay for day of injury?     yes    no
20. Did salary continue?                                     yes    no

## **OCCURRENCE/TREATMENT**

1. Time employee began work:                             am    pm
2. Date of injury or illness:
3. Time of occurrence:                                     am    pm
4. Last work date:
5. Date employer was notified of occurrence:
6. Date disability began:
7. Type of injury:
8. Part of body affected:
9. Did injury/illness/exposure occur on employer's premises?    yes    no
10. Department or location where accident or illness exposure occurred:
11. ZIP Code of injury site:
12. All equipment, materials or chemicals employee was using when accident or illness exposure occurred:
13. Specific activity the employee was engaged in when the accident or illness exposure occurred:
14. Work process the employee was engaged in when accident or illness exposure occurred:
15. How Injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill:
16. Date returned to work:
17. If fatal, give date of death:
18. Were safeguards or safety equipment provided?    Yes    No
19. Were they used?     Yes    No

## **MEDICAL PROVIDER**

1. Name of Physician or Health Care Provider:
2. Address:
3. City:
4. State:
5. Zip:
6. Name of Hospital or off site treatment facility:

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7. Address:
8. City:
9. State:
10. Zip:
11. Initial Treatment:  No Medical Treatment  
 Minor: Treatment by Employer  
 Minor: Clinic or Hospital  
 Emergency Care  
 Hospitalized greater than 24 hours  
 Future major medical/lost time anticipated

## **OTHER**

1. Witness name:
2. Witness Area Code & Phone #:
3. Date Administrator (TPA) notified:
4. Date Report Prepared:
5. Preparer's Name:
6. Preparer's Title:
7. Preparer's Area Code & Phone #:

## **TO BE ANSWERED BY EMPLOYEE'S DIRECT SUPERVISOR**

(Note this section can be completed and submitted as a supplement to your original First Report of Injury Filing. Do not hold up the initial filing of your First Report of Injury for this information. If you do choose to do a supplemental filing, please check the Supplemental filling box on the top of the form. )

1. Do you usually supervise this individual?  Yes  No  
If No, Explain:
2. Was accident immediately reported?  Yes  No  
If No, Explain:
3. Was employee working  Alone  With crew
4. Did you physically inspect the area where the injury occurred?  Yes  No  
If No, Explain:
5. Any unsafe conditions or unusually hazards present?  Yes  No  
If Yes, Explain:
6. Was employee wearing back support?  Yes  No  
If No, Explain:
7. Evidence of horseplay  Yes  No  
If Yes, Explain:
8. Evidence of intoxication  Yes  No  
If Yes, Explain:
9. Evidence of drug abuse  Yes  No  
If Yes, Explain:
10. Are you satisfied that the accident/injury occurred as described above?  Yes  No

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If No, Explain:

11. What additional training may have prevented this accident?
12. What additional training would you like Fund's Safety Director to provide?
13. What circumstances contributed to this accident?
14. What actions contributed to this accident?
15. What changes in circumstances or actions could have prevented this accident?
16. Your actions taken to minimize the chance of a recurrence?
17. Your future plans to minimize the chance of a recurrence?
18. Would you like to speak to any Fund Professional?  Yes  No  
If Yes, please list:

Supervisor's Name:

Date:

Distribution:

Claims Administrator  
Safety Director  
Safety Delegate  
Your records