Alton Fire & Rescue Department
Standard Operating Guidelines (SOG)

SOG 1.1.2 First Report of Personal Injury (Reference SOP 1.1.2)

PURPOSE: To ensure the reporting of any injury to Department personnel.

SCOPE: All Department members

SPECIFICS:

- EVERY injury shall be reported to the senior ranking member on the scene and documented within 24 hours on the First Report of Injury (FRI) form and the Notice of Accidental Injury or Occupational Disease form.
- All injuries/illnesses occurring on the fire ground or during a fire department activity that require hospital treatment shall be reported to the Fire Chief as soon as possible by the senior ranking member at the scene.
- All blood-to-blood contact shall be reported to the Fire Chief as soon as possible by the member having contact or the senior ranking member at the scene.

DATE: April 24, 2006
Revised: August 13, 2008:
Revised: December 15, 2008
Revised: April 20, 2009

Alton Fire & Rescue Department
Standard Operating Procedure (SOP)

SOP 1.1.2 First Report of Personal Injury

PURPOSE: To ensure the reporting of any injury to Department personnel.

SCOPE: All Department members

SPECIFICS:

- EVERY injury shall be reported to the senior ranking member on the scene and documented within 24 hours on the First Report of Injury (FRI) form and the Notice of Accidental Injury or Occupational Disease form (8aWCA). (**Attached** – can be printed)
    - These forms shall be completed and forwarded to the Executive Secretary of the Alton Fire and Rescue Department on the first working day following the injury in TRIPLICATE.
    - Individual personnel will be held accountable for reporting all injuries he/she sustains.
- All injuries/illnesses occurring on the fire ground or during a fire department activity that require hospital treatment shall be reported to the Fire Chief as soon as possible by the senior ranking member at the scene.
    - Senior Ranking member on the scene shall be accountable for reporting these cases to the Fire Chief.
- All blood-to-blood contact shall be reported to the Fire Chief as soon as possible by the member having contact or the senior ranking member at the scene.
    - Individual personnel will be held accountable for reporting all blood/body fluid contact as soon as the individual's medical condition allows.
    - In the event the medical condition does not allow him/her to report the blood-to-blood contact to the senior ranking member, the incident shall be reported to the Fire Chief, within 24 hours.

DATE: Approved: December 15, 2008 Revised: April 20, 2009

This form must be printed and sent to the NH Department of Labor and your insurance carrier.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE (Form 8WC)

NH DOL USE ONLY

Return to: The State of New Hampshire, Department of Labor
P.O. Box 2077, Concord, NH 03302-2077
(603) 271-3176 FAX: (603) 271-6149

***IMPORTANT;** Every employer shall file this report as soon as possible after knowledge of any occupational injury or disease to an employee, but no later than five days thereafter. Notice of disability of four or more days shall be filed no later than seven days after date of injury on Supplemental Report Form No. 13WCA. Failure to comply with any or all of the above carries a civil penalty of up to $2,500.00. RSA 281A:53.*

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: Town of Alton
40. Employers Federal ID: 02-6000015
41. If leased or temporary worker, client's business name:
42. Business Address of No. 39 above: P.O. Box 659
43. City/State: Alton, NH
44. Zip: 03809
45. Telephone Number: 603-875-0203
46. Insurance Co. (not agent) or Self Insured Group: CCMSI
47. Managed Care Program? Y or N. If yes, name Provider: Contact Paulette
48. No. of Employees: Full-time: 50 Part-time: 20
49. Is there a Written Safety Program in force? Yes
50. Is there an active Safety Committee? Yes
51. Business SIC Code
52. Type or Nature of Business in N.H.: Municipality
53. If report sent by Insurance Agency, state name:
54. Employer Signature:
55. Printed/Typed Name and Official Title: Paulette Wentworth, Finance Officer
56. Employee Signature (whenever possible):
57. Date of this report:

This form must be printed and sent to the NH Department of Labor

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
SPAULDING BUILDING
95 PLEASANT STREET
CONCORD, NEW HAMPSHIRE

NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE 8aWCA

(Please print or type)

To Town of Alton Phone # 603-875-0203
(Name of Employer)

P.O. Box 659, Alton, NH 03809
(Business Name and Address)

IN ACCORDANCE WITH RSA 281-A:20, This is to notify you that an injury occurred.

________________________________ SS # ______________
(Name of Injured Employee)

________________________________ Daytime Phone # ______________
(Address of Injured Employee)

____
(Date of Accident or First Treatment)

____
(Place Accident Happened)

Describe your injury or disease, and how it happened. Identify the body part(s) affected. ______________

____

____

____

I have been unable to work since my injury. ☐ Yes ☐ No

I have incurred the following medical bills.

Name of Doctor	Dates of Service	Amount
Name of Hospital	Dates of Service	Amount
Other	Dates of Service	Amount

________________________ ________________________
(Employer's Signature) (Employee's Signature)

________________________ ________________________
(Date) (Date)

This form can be returned to DOL with or without employer's signature.

NOTICE TO EMPLOYER

YOU MUST FILE AN EMPLOYER'S FIRST REPORT, Form No. 8WC, WITH THE LABOR COMMISSIONER AND THE NEAREST CLAIMS OFFICE OF YOUR INSURANCE CARRIER, AS SOON AS POSSIBLE AFTER ACQUIRING KNOWLEDGE OF THE OCCURRENCE OF AN OCCUPATIONAL INJURY OR DISEASE TO ONE OF YOUR EMPLOYEES OR UPON PRESENTATION OF THIS NOTICE BY HIM, BUT NO LATER THAN FIVE DAYS THEREAFTER. FAILURE TO COMPLY CARRIES AN AUTOMATIC CIVIL PENALTY OF UP TO $2500. (RSA 281-A:53)