QUALCARE INC

888-342-3839

QUALCARE, INC. FIRST ACCIDENT REPORT (FAR)

Taken by: _____Report Date to QC _____To Employer_____ Report Time:_____Caller : _____

Social Security # (*If available*) :

Injured EE Name: (check spelling)
Last: First:

Home Address:

DOB:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Sex: ☐ M ☐ F

Person Injury Reported To:

Date of Injury:

Time:

Employer/Municipality/School Board:

Location/Department:

Occupation:

Employment Status: ☐ Full-time ☐ Part-Time ☐ Seasonal ☐ Volunteer; Work Hours:_____

Witness (name & number)

Where accident occurred:

Did accident occur on premises? ☐ Yes ☐ No

City: State: Zip

Nature of Injury: (strain, contusion, laceration, etc.)

Injured Body Part:

Dominant Hand? ☐ Right ☐ Left

Accident Description: (Cause of Injury)

Has employee received medical attention? ☐ Yes ☐ No

If "yes", where?

Where is employee now?

Best way to reach employee:

Home Phone: Cell Phone: Work Phone: ext:

Was Safety Equipment Provided? ☐ Yes ☐ No

Were Safety Devices Used? ☐ Yes ☐ No

Is employee out of work? ☐ Yes ☐ No

Last date employee worked?

Date of Hire:

Salary/Wages: $_____ Number of days worked in week?_____

Shift: ☐ Days ☐ Evenings ☐ Nights

Does employee have another employer or attend school? If yes, name of employer or school:

Previous Medical Condition?

Current Medications?

Previous workers' compensation injury? Year and body part:

Primary Care Physician name and phone #:

Advised to call back for pharmacy ☐ Yes ☐ No; Advised to call NCM: ☐ Yes ☐ No

Initial Treatment PROVIDER/FACILITY: NAME/ADDRESS/PHONE:

Employment status: ☐

Was a child involved: ☐

Special Needs Child?: ☐ Yes ☐ No

Age of Child:

Initial Treatment Directed by:

Case Assigned to: