INTEGRATED NOTIFICATION SYSTEM (INS)
FIRST REPORT OF INJURY HARDCOPY
888-INS-YORK (888-467-9675)

DATE AND TIME REPORT INITIATED AM PM	DATE AND TIME OF INJURY/EXPOSURE AM PM

NAME OF INJURED EMPLOYEE	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE #

HOME ADDRESS	MARITAL STATUS	GENDER	WORK PHONE #

CITY/STATE/ZIP	DATE OF HIRE	JOB TITLE OR OCCUPATION	WORKSHIFT/ TIME BEGAN WORK

EMPLOYER NAME	EMPLOYER'S ADDRESS/CITY/STATE/ZIP	DATE EMPLOYER NOTIFIED

EMPLOYER POLICY #	EMPLOYER PHONE #	EMPLOYER CLIENT CODE (If applicable)

HOURS WORKED PER DAY	DAYS WORKED PER WEEK	FULL/PART TIME/ SEASONAL/VOLUNTEER	WAGES PER HOUR
LAST DAY WORKED	**DATE DISABILITY BEGAN**	**RETURN TO WORK DATE**	**BODY PART(S) INJURED**

IF OUT OF STATE INJURY, SPECIFY STATE OF INJURY	WERE SAFEGUARD OR SAFETY EQUIPMENT PROVIDED? YES or NO	WERE SAFEGUARD OR SAFETY EQUIPMENT USED? YES or NO

DESCRIPTION OF INJURY

DID INJURY OCCUR ON EMPLOYER'S PREMISES YES OR NO	WORKER PAID FOR DATE OF INJURY YES OR NO

DO YOU AGREE WITH INJURY DESCRIPTION? YES or NO	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WC YES OR NO	LAST DAY WAGES WILL BE PAID INSTEAD OF WC /______/

MEDICAL CARE PROVIDED BY:	DATE OF TREATMENT

WITNESS NAME AND PHONE NUMBER	SUPERVISOR NAME AND PHONE NUBER

NOTIFIED BY: NAME AND PHONE NUMBER