

FIRST AID REPORT

Send this notice directly to **NCAComp, Inc** after the mishap occurs. Answer ALL questions fully.

NAME OF EMPLOYER: _____

Date of Mishap: _____ Date of this Report: _____

Time of Mishap: _____

Location where incident occurred: _____

Time of Injury: _____

Witness(es) to incident: _____

** NAME OF EMPLOYEE: _____ Date of Hire: _____

Job Title: _____

Address: _____

Home Telephone: _____ SS#: _____

Was Medical Care Provided? (Y/N) ____ If yes, when? _____

Where was employee sent for medical treatment? _____

Nature of Injury (ie: lt. Arm/ back etc) _____

How did the incident occur? _____

Date reported to foreman/supervisor: _____ Supervisor Signature _____

Employee Signature _____

FAX TO (716) 842-0018
OR MAIL DIRECTLY TO:
NCAComp, Inc.
14 Lafayette Square, Suite 700
Buffalo, New York 14203