NEEM Incident Report

Please list in detail the events of the incident.

Date of report: _____

Date of Incident: _____

Reported to: _____

Jobsite: _____ Equipment: _____ NEEM Equip # _____

Employee operating equipment: _____

Description of incident: _____

Where did incident occur? _____

What happened? _____

_____

Actions taken: _____

_____

_____

List factors that contributed to the incident: _____

_____

Witnesses? Yes or No Name(s): _____

Police report filed? Yes or No Report #: _____

Auto accident? Yes or No Other vehicle involved? Yes or No

Other vehicle damage/information: _____

_____

Any injuries? Yes or No Name(s): _____

Describe injuries: _____

_____

Injured employees must complete a Notice of Accidental Injury Form.
See attached form.

_____
NEEM Employee Signature

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_____ Phone #_____
(Name of **Employer**)

_____
(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)