WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

011503049564

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG CASE #	REPORT PURPOSE CODE
AUTO-CHLOR SYSTEM **450 FERGUSON DRIVE** **MOUNTAIN VIEW, CA 94043**	JURISDICTION **NJ**	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER **011503049564**		
INDUSTRY CODE / EMPLOYER FEIN **94-1663270**	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) **685 GOTHAM PARKWAY** **CARLSTADT, NJ 07072**	LOCATION # **24000-620** PHONE # **(650) 967-3085**	

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) **GB-NORTHEAST REGIONAL** **PO BOX 2934** **CLINTON, IA 52733-2934** **(800) 307-5256**

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
Cook, Dylon	**08/31/2001**	*****-**-3667**	**11/07/2022**	

ADDRESS (INCL ZIP)	SEX	MARITAL STATUS	OCCUPATION/JOB TITLE
54 Union St #14 **Lodi, NJ 07644**	X M MALE F FEMALE U UNKNOWN	U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	**Service and Sales Representative** EMPLOYMENT STATUS **Full-Time**
PHONE **(201) 838-6812**	# OF DEPENDENTS		NCCI CLASS CODE

RATE PER:			DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?			DID SALARY CONTINUE?		
	☐ DAY ☐ WEEK	☐ MONTH ☐ OTHER:		☐ YES	☐ NO		☐ YES	☐ NO	

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
☐ AM ☐ PM	**12/04/2024**	( ) CANNOT BE DETERMINED **11:50** X AM ☐ PM		**12/06/2024**	

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
Sarah Bechtol	**Strain**	**Right leg**
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES X NO	TYPE OF INJURY/ILLNESS CODE **52**	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
AUTO CHLOR BRANCH 620 **685 GOTHAM PARKWAY CARLSTADT, NJ 07072**	
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

Employee slipped going down wet stairs and strained his right thigh and knee

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		WERE THEY USED?	
		☐ YES	☐ NO	☐ YES	☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HRS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER
	12/09/2024		