Employer's First Report of Injury Form (FROI)

Submit form to: Consolidated Benefits Resources
PO Box 581630
Tulsa, OK 74158
Email: newclaim@cbremail.com
Fax: 918-594-5171 of (888) 594-5171
www.CBRCloud.com

Employee Information

Full Name of Employee- Last, First, Middle		Date of Birth	Sex
Complete Mailing Address (include, city, state, zip code)		Employee Email Address	
Home Telephone Number	Work Telephone Number	Mobile Telephone Number	
Occupation/Job Title	Job Description	NCCI Class Code	Length of Employment: Years: Months: Date of Hire:
Organization/Location	Department/Division	Average Weekly Wage	

Employer/Insurance Information

Employer Name				Federal Tax ID#	Telephone Number
Address	City	State	Zip	Type of Ownership: Private ☐ State Gov't ☐ County Gov't ☐ Local Gov't ☐	
Type of Business (Example: manufacturing, food service, construction)					NAICS Number
Employer's Insurance Carrier/Own Risk Group Consolidated Benefits Resources/		Policy/Self-Insured Number		Policy Period	
Address PO Box 581630	City Tulsa	State OK	Zip 74158	Telephone Number (918) 594-5170	

Injury Details

Date of accident/last exposure	Time of accident/last exposure	Time workday began
Injury Resulted from: Single Incident ☐ Cumulative Trauma ☐ Occupational Disease ☐		Did the employee die? If yes, on what date?
Date Employer notified	Place of Accident/Occurrence City County State Zip Code	Does employee participate in a certified workplace medical plan: If yes, name of CWMP:
Last Date employee worked	Has employee returned to work? If yes, on what date?	OSHA Recordable? If so Log Case Number:

Nature of Injury/Illness

Identify part(s) of body involved in injury/illness

Describe activities when injury occurred with details on how event occurred. Include object or substance which directly injured the employee.

Full Name and address of treating physician (please be complete)

Additional Information/Comments:

Signature of Preparer: _____ Date:_____

Name and Title of Preparer (Please Print): _____