

# WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

<b>General</b>	Employer (Name & Address incl. zip)				Carrier/Administrator Claim Number		Report Purpose Code																						
					Jurisdiction		Jurisdiction Claim No.																						
	Insured Report No.																												
	Employer's Location Address (if different)						Location No.																						
NAICS Code				Employer FEIN				Phone No.																					
<b>Carrier/Claims Admin</b>	Carrier (Name, Address & Phone Number)				Policy Period		Claims Admin (Name, Address & Phone Number)																						
					To																								
					<input type="checkbox"/> Check if self insured																								
	Carrier FEIN			Policy Number or Self-Insured Number			Administrator FEIN																						
Agent Name & Code Number																													
<b>Employee</b>	Legal Name (Last, First, Middle)			Birth Date		Social Security Number			Date Hired		State of Hire																		
	Address (Incl. Zip)			Sex		Marital Status			Occupation/Job Title																				
				<input type="checkbox"/> Male		<input type="checkbox"/> Unmarried/Single/Div.																							
				<input type="checkbox"/> Female		<input type="checkbox"/> Married																							
	Phone			<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated			Employment Status																				
				No. of Dependents		<input type="checkbox"/> Unknown			NCCI Class Code																				
Wage Rate		<input type="checkbox"/> Day		<input type="checkbox"/> Month		# Days Worked/WK		Full Pay for Date of Injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No																			
\$		<input type="checkbox"/> Week		<input type="checkbox"/> Other		# Hrs Worked per Day		Did Salary Continue?		<input type="checkbox"/> Yes <input type="checkbox"/> No																			
<b>Occurrence</b>	Time Employee Began Work		<input type="checkbox"/> AM <input type="checkbox"/> PM		Date of Injury or Illness		Time Occurred		<input type="checkbox"/> AM <input type="checkbox"/> PM		Last Work Date		Date Employer Notified		Date Disability Began														
	Employer Contact Name/Phone Number						Type of Illness/Injury				Part of Body Affected																		
	Did Injury/Illness Exposure Occur on Employer's Premises?						Yes <input type="checkbox"/> No <input type="checkbox"/>		Type of Illness/Injury Code				Part of Body Affected Code																
	Department or location where accident or illness exposure occurred								All Equipment, Materials, or Chemicals Employee Using upon Occurrence																				
	Specific Activity Employee Engaged in at Time of Occurrence								Work Process the Employee Was Engaged in at Time of Occurrence																				
	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.												Cause of Injury Code																
	Date Returned to Work				If Fatal, Date of Death				Were Safeguards or Safety Equipment Provided?				<input type="checkbox"/> Yes <input type="checkbox"/> No																
													Were they used? <input type="checkbox"/> Yes <input type="checkbox"/> No																
<b>Treatment</b>	Physician/Health Care Provider (Name & Address)					Hospital (Name & Address)					Initial Treatment																		
	<table style="width: 100%; border: none;"> <tr> <td style="width: 20px;">0</td> <td><input type="checkbox"/></td> <td>No Medical Treatment</td> </tr> <tr> <td>1</td> <td><input type="checkbox"/></td> <td>Minor: By Employer</td> </tr> <tr> <td>2</td> <td><input type="checkbox"/></td> <td>Minor Clinic/Hosp</td> </tr> <tr> <td>3</td> <td><input type="checkbox"/></td> <td>Emergency Care</td> </tr> <tr> <td>4</td> <td><input type="checkbox"/></td> <td>Hospitalized – 24 hr.</td> </tr> <tr> <td>5</td> <td><input type="checkbox"/></td> <td>Anticipated Major Med/Lost Time</td> </tr> </table>												0	<input type="checkbox"/>	No Medical Treatment	1	<input type="checkbox"/>	Minor: By Employer	2	<input type="checkbox"/>	Minor Clinic/Hosp	3	<input type="checkbox"/>	Emergency Care	4	<input type="checkbox"/>	Hospitalized – 24 hr.	5	<input type="checkbox"/>
0	<input type="checkbox"/>	No Medical Treatment																											
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4	<input type="checkbox"/>	Hospitalized – 24 hr.																											
5	<input type="checkbox"/>	Anticipated Major Med/Lost Time																											
<b>Other</b>	Signature of Injured Employee, or Signature on File, Date					Witness to Accident (Name & Phone Number)																							
	Date Administrator Notified				Date Prepared		Preparer's Name & Title				Preparer's Phone Number																		

Filing this report is not an admission of liability. This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made. Idaho Industrial Commission, P.O. Box 83720, Boise, ID 83720-0041 IC Form IA-1 (08/2013)