

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General	Employer (Name & Address incl. zip)				Carrier/Administrator Claim Number		Report Purpose Code								
					Jurisdiction		Jurisdiction Claim No.								
					Insured Report No.										
	NAICS Code				Employer FEIN		Employer's Location Address (if different)				Location No.				
										Phone No.					
Carrier/Claims Admin	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															
Employee	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	Employment Status									
	<input type="checkbox"/> Unknown	<input type="checkbox"/> Separated													
	Phone			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		
Occurrence	Time Employee Began Work		<input type="checkbox"/> AM	Date of Injury or Illness		Time Occurred		<input type="checkbox"/> AM	Last Work Date		Date Employer Notified		Date Disability Began		
			<input type="checkbox"/> PM					<input type="checkbox"/> PM							
	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"/>	Type of Illness/Injury Code				Part of Body Affected Code			
					No		<input type="checkbox"/>								
	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
Treatment	Physician/Health Care Provider (Name & Address)				Hospital (Name & Address)				Initial Treatment						
									0 <input type="checkbox"/>	No Medical Treatment					
Other	Signature of Injured Employee, or Signature on File, Date				Witness to Accident (Name & Phone Number)				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"/>	Anticipated Major Med/Lost Time					
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)