Print Form

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.

Employer's Location Address (if different) | Location No.

Sic Code | Employer FEIN | Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)

Policy Period

To

☐ Check if self insured

Claims Admin (Name, Address & Phone Number)

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: ☐ Male ☐ Female ☐ Unknown

Marital Status: ☐ Unmarried/ Single/Div. ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

Phone

No. of Dependents

NCCI Class Code

Wage Rate $ ☐ Day ☐ Week ☐ Month ☐ Other

Days Worked/WK

Hrs Worked per Day

Full Pay for Date of Injury? ☐ Yes ☐ No

Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM

Date of Injury or Illness

Time Occurred ☐ AM ☐ 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 ☐ No

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? ☐ Yes ☐ No

Were they used? ☐ Yes ☐ No

Treatment

Physician/Health Care Provider (Name & Address)

Hospital (Name & Address)

Initial Treatment

- 0 ☐ No Medical Treatment
- 1 ☐ Minor: By Employer
- 2 ☐ Minor Clinic/Hosp
- 3 ☐ Emergency Care
- 4 ☐ Hospitalized – 24 hr.
- 5 ☐ Anticipated Major Med/Lost Time

Other

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 (2/98)