STATE OF IDAHO WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP) (1)

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE # (2)

SIC CODE

EMPLOYER FEIN

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NUMBER) (3)

POLICY PERIOD

TO

CHECK IF SELF INSURED

CLAIMS ADMIN (NAME, ADDRESS & PHONE NO.)

CARRIER FEIN

POLICY NUMBER OR SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT CODE NUMBER

AGENT NAME

EMPLOYEE

LEGAL NAME (LAST, FIRST, MIDDLE) (4)

BIRTH DATE (5)

SOCIAL SECURITY NUMBER (6)

DATE HIRED (7)

STATE OF HIRE (8)

ADDRESS (INCL ZIP) (9)

SEX (10)

- M MALE
- F FEMALE
- U UNKNOWN

MARITAL STATUS (11)

- U UNMARRIED/ SINGLE/DIV.
- M MARRIED
- S SEPARATED
- K UNKNOWN

OCCUPATION /JOB TITLE (12)

EMPLOYMENT STATUS (13)

PHONE (14)

OF DEPENDENTS (15)

NCCI CLASS CODE

WAGE RATE (16) PER: A DAY, B WEEK, C MONTH, D OTHER:

DAYS WORKED/WK (17)

HOURS WORKED/DAY (18)

FULL PAY FOR DATE OF INJURY? YES NO

DID SALARY CONTINUE? YES NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK (19) A AM, B PM

DATE OF INJURY/ILLNESS (20)

TIME OCCURRED (21) A AM, B PM

LAST WORK DATE (22)

DATE EMPLOYER NOTIFIED (23)

DATE DISABILITY BEGAN (24)

EMPLOYER CONTACT NAME/PHONE NUMBER (25)

TYPE OF INJURY/ILLNESS (26)

PART OF BODY AFFECTED (27)

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? (28) YES NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED (29)

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE USING UPON OCCURRENCE (30)

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN AT TIME OF OCCURRENCE (31)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN AT TIME OF OCCURRENCE (32)

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 EMPLOYEE ILL (33)

CAUSE OF INJURY CODE

DATE RETURNED TO WORK (34)

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) (35)

HOSPITAL (NAME & ADDRESS) (36)

INITIAL TREATMENT (37)

- 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 (38)

WITNESS TO ACCIDENT (NAME & PHONE NUMBER) (39)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED (40)

PREPARER'S NAME & TITLE (41)

PREPARER'S PHONE NUMBER (42)

Return top two copies to Industrial Commission. Retain pink copy for your records.