

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.									
NAICS Code				Employer FEIN				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"/> Female	<input type="checkbox"/> Unmarried/Single/Div.	<input type="checkbox"/> Married									
				<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Separated	Employment Status									
	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	<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		
Treatment	Physician/Health Care Provider (Name & Address)				Hospital (Name & Address)				Initial Treatment							
	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	No Medical Treatment	Minor: By Employer	Minor Clinic/Hosp	Emergency Care	Hospitalized – 24 hr.	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 (08/2013)