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

GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

SIC CODE | EMPLOYER FEIN | PHONE #

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NUMBER)

POLICY PERIOD

TO

☐ CHECK IF SELF INSURED

CLAIMS ADMIN (NAME, ADDRESS &PHONE NO.)

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
- M MALE
- F FEMALE
- U UNKNOWN

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

OCCUPATION /JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | K | NCCI CLASS CODE

WAGE RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER: | # DAYS WORKED/ WK | FULL PAY FOR DATE OF INJURY? ☐ YES ☐ NO | DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OCCURED ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISIBILITY BEGAN

EMPLOYER CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | TYPE OF INJURY/ILLNESS 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 EMPOYEE 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