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	
Phone	No. of Dependents		Employment Status	
			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.

Other

Signature of Injured Employee, or Signature on File, Date	Witness to Accident (Name & Phone Number)	5 ☐ 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 (2/98)