

SAMPLE

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General	Employer (Name & Address incl. zip) ABC Agency 123 Main Street Boise ID 83704				Carrier/Administrator Claim Number		Report Purpose Code		
	NAICS Code		Employer FEIN		Jurisdiction		Jurisdiction Claim No.		
	Insured Report No.				Employer's Location Address (if different)				Location No.
	Phone No.								
Carrier/Claims Admin	Carrier (Name, Address & Phone Number) State Insurance Fund 1215 W. State Street, Boise, ID, 83702 208-332-2100				Policy Period 01/01/2022 To 12/31/2022 <input type="checkbox"/> Check if self insured		Claims Admin (Name, Address & Phone Number)		
	Carrier FEIN		Policy Number or Self-Insured Number WC123456789			Administrator FEIN			
	Agent Name & Code Number								
Employee	Legal Name (Last, First, Middle) Doe, Fake Employee			Birth Date 02/14/1975	Social Security Number 123-45-6789		Date Hired 01/10/2018		State of Hire Idaho
	Address (Incl. Zip) 567 1st. Street Boise, ID 83704			Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Marital Status <input type="checkbox"/> Unmarried/Single/Div. <input checked="" type="checkbox"/> Married <input type="checkbox"/> Separated		Occupation/Job Title Administrative Assistant		
	Phone 111-333-8888			No. of Dependents 2	Unknown		Employment Status Full Time NCCI Class Code 8810		
	Wage Rate \$ 21.15		<input type="checkbox"/> Day <input type="checkbox"/> Week	<input type="checkbox"/> Other	# Days Worked/WK 5 # Hrs Worked per Day 8		Full Pay for Date of Injury? Did Salary Continue?		
	<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		Date of Injury or Illness 10/07/2022	Time Occurred 1:35	<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	Last Work Date 10/07/2022	Date Employer Notified 10/07/2022		Date Disability Began
	Employer Contact Name/Phone Number Mary Roberts 111-444-7777				Type of Illness/Injury Strain		Part of Body Affected Low Back		
Did Injury/Illness Exposure Occur on Employer's Premises?				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			Part of Body Affected Code		
Occurrence	Department or location where accident or illness exposure occurred 123 Main Street, Boise, ID 83704				All Equipment, Materials, or Chemicals Employee Using upon Occurrence None				
	Specific Activity Employee Engaged in at Time of Occurrence Lifting				Work Process the Employee Was Engaged in at Time of Occurrence Lifting boxes of paper				
	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. Employee lifted a 5 pound box of paper to put on a shelf near the printer when they felt a twinge in their lower back.							Cause of Injury Code	
	Date Returned to Work 10/07/2022		If Fatal, Date of Death		Were Safeguards or Safety Equipment Provided? Were they used?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Treatment	Physician/Health Care Provider (Name & Address) Urgent Care 911 Emergency Way Boise, ID 83705			Hospital (Name & Address)			Initial Treatment 0 <input type="checkbox"/> No Medical Treatment 1 <input type="checkbox"/> Minor: By Employer 2 <input checked="" type="checkbox"/> Minor Clinic/Hosp 3 <input type="checkbox"/> Emergency Care 4 <input type="checkbox"/> Hospitalized – 24 hr. 5 <input type="checkbox"/> Anticipated Major Med/Lost Time		
	Signature of Injured Employee, or Signature on File, Date			Witness to Accident (Name & Phone Number) None					
Other	Date Administrator Notified		Date Prepared	Preparer's Name & Title Mary Roberts, HR Specialist Sr.			Preparer's Phone Number 111-444-7777		

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)

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