## WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

| Image: Second |        | Employer (Name & Address incl. zip)   |  |  |      |  | Carrier/Administrator Claim Number Report Purpose Code                |                                |                      |                            |                                    |                |      |  |
|---|--------|---|--|--|------|--|---|--------------------------------|----------------------|----------------------------|------------------------------------|----------------|------|--|
| Image: Specific Address (If different) Location No.   NACS Code Employer FEIN   Carrier (Name, Address & Phone Number) Policy Period   Claims Admin (Name, Address & Phone Number) To   To Claims Admin (Name, Address & Phone Number)   Agent Name & Code Number Address (Incl. Zip)   Address (Incl. Zip) Set   Matter Status State of Hire   Address (Incl. Zip) Set   Matter Status Claims Admin (Name, Address & Phone Number)   To Set   Phone No. O Dependents   Uhrown NCCI Class Code   Wage Rate Date Address (Incl. Zip)   Wage Rate Date Address (Incl. Zip)   Wage Rate Work Date Other   Phone No. O Dependents   Uhrown NCCI Class Code   Wage Rate Date Address (Incl. Zip)   Employer Contact Name/Phone Number Cocurred   Premise? No   To Date Address (Incl. Zip)   Period Cocurred   Premise? Date Address (Incl. Zip)   Premise? No   Premise? Date Address (Incl. Zip)   Premise? No   Date Rate Date Matter Education Number </th <th></th> <th></th> <th></th> <th></th> <th></th> <th>ľ</th> <th>Juriso</th> <th>liction</th> <th>Jurisd</th> <th>diction Claim N</th> <th>lo.</th> <th></th> <th></th>  |        |   |  |  |      | ľ  | Juriso  | liction                        | Jurisd               | diction Claim N            | lo.                                |                |      |  |
| NAICS Code       Employer FEIN       Phone No.         Carrier (Name, Address & Phone Number)       Policy Period       Claims Admin (Name, Address & Phone Number)         To       D       Deck if estimated       Claims Admin (Name, Address & Phone Number)         To       D       Deck if estimated       Claims Admin (Name, Address & Phone Number)         Agent Name & Code Number       Administrator FEIN       Administrator FEIN         Agent Name & Code Number       State of Hire       State of Hire         Address (Incl. Zip)       Sex       Morital Status       Occupation/Job Title         Phone       No. of Dependents       Unknown       Date Hired       State of Hire         Wage Rate       Date of Injury       Temployment Status       Date Date of Injury/       No.         Wage Rate       Date of Injury       Time       Address Code       No.         Wage Rate       Date of Injury       Time       Address Date Employer Notified       Date Date Datability         Began Work       Phone No. of Dependents       Virk Date Of Body Affected       No.       Date Datability         Began Work       Date of Injury Time       Address Support Cour on Employer Yes       No.       Date Of Injury State Address         Began Work       Date of Injury Time       Address Operanet<  | ral    |   |  |  |      |  | Insured Report No.  |                                |                      |                            |                                    |                |      |  |
| Carrier (Name, Address & Phone Number)       Palicy Period       Claims Admin (Name, Address & Phone Number)         To       To       To         Carrier FEIN       Policy Number or Self-Insured Number       Administrator FEIN         Agent Name & Code Number       Issued       Administrator FEIN         Agent Name & Code Number       Bith Date       Social Security Number       Date Hired       State of Hire         Address (nd. Zp)       Sex       Marital Status       Occupation/Job Title       State of Hire         Address (nd. Zp)       Sex       Marital Status       Occupation/Job Title       No         Male       Uninnown       Displecibly.       Employment Status       No         Wage Rate       Day       Month       Bay Work Note       Part of Body Affected       No         Wage Rate       Day       Month       Second PM       Last Work Date       Date Employer Notified       Date Disability         Began       Week       Other       PM       Last Work Date       Date Disability       Began         Time Employee       AM       Date of Injury       Time employee Notified       Date Disability       Began         Did Injury/Insek Szobare Occurrent       No       Did Second Number       Part of Body Affected Code   | Gene   |   |  |  |      |  | Employer's Location Address (if di                                    |                                |                      | lress (if differe          | fferent) Location No.              |                |      |  |
| Carrier (Name, Address & Phone Number)       Palicy Period       Claims Admin (Name, Address & Phone Number)         To       To       To         Carrier FEIN       Policy Number or Self-Insured Number       Administrator FEIN         Agent Name & Code Number       Issued       Administrator FEIN         Agent Name & Code Number       Bith Date       Social Security Number       Date Hired       State of Hire         Address (nd. Zp)       Sex       Marital Status       Occupation/Job Title       State of Hire         Address (nd. Zp)       Sex       Marital Status       Occupation/Job Title       No         Male       Uninnown       Displecibly.       Employment Status       No         Wage Rate       Day       Month       Bay Work Note       Part of Body Affected       No         Wage Rate       Day       Month       Second PM       Last Work Date       Date Employer Notified       Date Disability         Began       Week       Other       PM       Last Work Date       Date Disability       Began         Time Employee       AM       Date of Injury       Time employee Notified       Date Disability       Began         Did Injury/Insek Szobare Occurrent       No       Did Second Number       Part of Body Affected Code   |        | NAICS Code  |  |  |      |  |   |                                | Phone No.            |                            | Phone No.                          |                |      |  |
| Image: state of high       Policy Number or Self-Insured Number       Administrator FEIN         Agent Name & Code Number       Policy Number or Self-Insured Number       Administrator FEIN         Address (Incl. Zip)       Birth Date       Social Security Number       Date Hired       State of Hire         Address (Incl. Zip)       Sex       Marinal Status       Cocupation/Job Title         Image: Single/Div.       Fernale       Employment Status         Phone       No. of Dependents       Unknown       NCCI Class Code         Wage Rate       Date of Injury       Yes       No.         Began Work       Other       #New Workset workset with Status       Date Disability         Began Work       Oncurred       Martine of Injury       Part of Body Affected Code         Image: Signature or location where accident or illness exposure occurred       All Equipment, Materials, or Chemicals Employee Using upon Occurrence         More here y used?       No       Department or location where accident or illness exposure occurred       All Equipment, Materials, or Chemicals Employee Using upon Occurrence         More here y used?       India Transment       Work Process the Employee Was Engaged in at Time of Occurrence       Work Process the Employee Was Engaged in at Time of Occurrence         No       Date Returned to Work       If Fatal, Date of Death       Were Safeguards or  |        |   |  |  |      |  |   |                                |                      |                            |                                    |                |      |  |
| Legal Name (Last, First, Middle)       Birth Date       Social Security Number       Date Hired       State of Hire         Address (Incl. Zip)       Sex       Marital Status       Occupation/Job Title         Maile       Umnamic       Coupation/Job Title         Phone       No. of Dependents       Employment Status         Wage Rate       Day       Month       Separated         Wage Rate       Day       Month       Phone       No. of Dependents         Time Employee       AM       Date of Injury       Yes       No         Separated       Wage Rate       Day       Month       Phone       No         Time Employee       AM       Date of Injury       Time       No       Desponse       No         Began Work       FM       Otter       PHre Wriked per Day       Did Statary Continue?       Yes       No         Employer Contact Name/Phone Number       Type of Illness/Injury       Part of Body Affected       Dode       Desparate       Desparate       Code       Secific Activity Employee Engaged in at Time of Occurrence       Work Process the Employee Was Engaged in at Time of Occurrence       Code       Code       Code       Code       Code       Code       No       Desparate       No       Desparate       No <t< th=""><th></th><th colspan="4">Carrier (Name, Address &amp; Phone Number)</th><th>-</th><th colspan="3">Policy Period Claims Adn</th><th>laims Admin (</th><th colspan="3">nin (Name, Address &amp; Phone Number)</th></t<>   |        | Carrier (Name, Address & Phone Number)  |  |  |      | -  | Policy Period Claims Adn  |                                |                      | laims Admin (              | nin (Name, Address & Phone Number) |                |      |  |
| Legal Name (Last, First, Middle)       Birth Date       Social Security Number       Date Hired       State of Hire         Address (Incl. Zip)       Sex       Marital Status       Occupation/Job Title         Maile       Umnamic       Coupation/Job Title         Phone       No. of Dependents       Employment Status         Wage Rate       Day       Month       Separated         Wage Rate       Day       Month       Phone       No. of Dependents         Time Employee       AM       Date of Injury       Yes       No         Separated       Wage Rate       Day       Month       Phone       No         Time Employee       AM       Date of Injury       Time       No       Desponse       No         Began Work       FM       Otter       PHre Wriked per Day       Did Statary Continue?       Yes       No         Employer Contact Name/Phone Number       Type of Illness/Injury       Part of Body Affected       Dode       Desparate       Desparate       Code       Secific Activity Employee Engaged in at Time of Occurrence       Work Process the Employee Was Engaged in at Time of Occurrence       Code       Code       Code       Code       Code       Code       No       Desparate       No       Desparate       No <t< th=""><th>dmin</th><th colspan="5"></th><th>То</th><th colspan="5">То</th><th></th></t<>  | dmin   |   |  |  |      |  | То  | То                             |                      |                            |                                    |                |      |  |
| Legal Name (Last, First, Middle)       Birth Date       Social Security Number       Date Hired       State of Hire         Address (Incl. Zip)       Sex       Marital Status       Occupation/Job Title         Maile       Umnamic       Coupation/Job Title         Phone       No. of Dependents       Employment Status         Wage Rate       Day       Month       Separated         Wage Rate       Day       Month       Phone       No. of Dependents         Time Employee       AM       Date of Injury       Yes       No         Separated       Wage Rate       Day       Month       Phone       No         Time Employee       AM       Date of Injury       Time       No       Desponse       No         Began Work       FM       Otter       PHre Wriked per Day       Did Statary Continue?       Yes       No         Employer Contact Name/Phone Number       Type of Illness/Injury       Part of Body Affected       Dode       Desparate       Desparate       Code       Secific Activity Employee Engaged in at Time of Occurrence       Work Process the Employee Was Engaged in at Time of Occurrence       Code       Code       Code       Code       Code       Code       No       Desparate       No       Desparate       No <t< th=""><th>ms A</th><th colspan="5"></th><th colspan="6"></th></t<>  | ms A   |   |  |  |      |  |   |                                |                      |                            |                                    |                |      |  |
| Legal Name (Last, First, Middle)       Birth Date       Social Security Number       Date Hired       State of Hire         Address (Incl. Zip)       Sex       Marital Status       Occupation/Job Title         Maile       Umnamic       Coupation/Job Title         Phone       No. of Dependents       Employment Status         Wage Rate       Day       Month       Separated         Wage Rate       Day       Month       Phone       No. of Dependents         Time Employee       AM       Date of Injury       Yes       No         Separated       Wage Rate       Day       Month       Phone       No         Time Employee       AM       Date of Injury       Time       No       Desponse       No         Began Work       FM       Otter       PHre Wriked per Day       Did Statary Continue?       Yes       No         Employer Contact Name/Phone Number       Type of Illness/Injury       Part of Body Affected       Dode       Desparate       Desparate       Code       Secific Activity Employee Engaged in at Time of Occurrence       Work Process the Employee Was Engaged in at Time of Occurrence       Code       Code       Code       Code       Code       Code       No       Desparate       No       Desparate       No <t< th=""><th>r/Clai</th><th colspan="4">Carrier FEIN Policy Number or Self-Insured N</th><th>Numbe</th><th colspan="3"></th><th>dministrator F</th><th colspan="4">ator FEIN</th></t<>   | r/Clai | Carrier FEIN Policy Number or Self-Insured N  |  |  |      | Numbe  |   |                                |                      | dministrator F             | ator FEIN                          |                |      |  |
| Legal Name (Last, First, Middle)       Birth Date       Social Security Number       Date Hired       State of Hire         Address (Incl. Zip)       Sex       Marital Status       Occupation/Job Title         Maile       Umnamic       Coupation/Job Title         Phone       No. of Dependents       Employment Status         Wage Rate       Day       Month       Separated         Wage Rate       Day       Month       Phone       No. of Dependents         Time Employee       AM       Date of Injury       Yes       No         Separated       Wage Rate       Day       Month       Phone       No         Time Employee       AM       Date of Injury       Time       No       Desponse       No         Began Work       FM       Otter       PHre Wriked per Day       Did Statary Continue?       Yes       No         Employer Contact Name/Phone Number       Type of Illness/Injury       Part of Body Affected       Dode       Desparate       Desparate       Code       Secific Activity Employee Engaged in at Time of Occurrence       Work Process the Employee Was Engaged in at Time of Occurrence       Code       Code       Code       Code       Code       Code       No       Desparate       No       Desparate       No <t< th=""><th>arrie</th><th>Agent Name &amp; Code Number</th><th></th><th colspan="4"></th><th colspan="3"></th></t<>   | arrie  | Agent Name & Code Number  |  |  |      |  |   |                                |                      |                            |                                    |                |      |  |
| Address (Incl. Zip)       Sex       Marital Status       Occupation/Job Title         geo       Male       Ummarried/<br>Signet/Div.       Employment Status         Phone       No. of Dependents       Unknown       NCCI Class Code         Wage Rate       Day       Month       # Day       No. of Dependents         Wage Rate       Day       Month       # Day       No. of Dependents         Time Employee       AM       Date of Injury       Yes       No.         Began Work       PhM       Date of Injury       Time       Date Disability         Began Work       PhM       Date of Injury       Time       Date Disability         Began Work       Print       Occurred       PM       Last Work Date       Date Employer Notified       Date Disability         Began Work       Print       or Illness/Injury       Part of Body Affected       Dote         Did Injury/Illness Exposure Occur on Employer's       Yes       No       Part of Body Affected Code         Premises?       No       Date of Injury       Part of Body Affected Code         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.       Descrif Maria Sta   | 0      |   |  |  |      |  |   |                                |                      |                            |                                    |                |      |  |
| Male       Ummaried/Single/Div.         Phone       Male       Maried       Employment Status         Phone       No. of Dependents       Unknown       NCCI Class Code         Wage Rate       Day       Month       # Days WorkdWiK       Full Pay for Date of Injury?       Yes       No.         Time Employee       AM       Date of Injury       Time       Male       S       Date of Injury       No.         Began Work       PM       Date of Injury       Time       AM       Date of Injury       Part of Body Affected         Did Injury/Illness Exposure Occur on Employer's       Yes       Part of Body Affected Code       Part of Body Affected Code         Department or location where accident or illness exposure occurred       All Equipment, Materials, or Chemicals Employee Using upon Occurrence         How injury or illness/abnormal health condition occurred.       Describe the sequence of events and include any objects or substances       Cause of Injury         Date Returned to Work       If Fatal, Date of Death       Were Safeguards or Safety Equipment Provided?       Yes       No         Physician/Health Care Provider (Name & Address)       Hospital (Name & Address)       Initial Treatment Minor: By Employer       No         Date Administrator Notified       Date Prepared       Preparer's Name & Title       Preparer's Phone Number </th <th rowspan="3">vee</th> <th colspan="3">Legal Name (Last, First, Middle) Birth</th> <th>Soci</th> <th>ial Secu</th> <th>irity Nu</th> <th>mber</th> <th>Date I</th> <th colspan="2">Date Hired</th> <th colspan="2">State of Hire</th>  | vee    | Legal Name (Last, First, Middle) Birth  |  |  | Soci | ial Secu   | irity Nu  | mber                           | Date I               | Date Hired                 |                                    | State of Hire  |      |  |
| Image: Second |        | Address (Incl. Zip)   |  |  |      |  |   |                                | Occupation/Job Title |                            | е                                  |                |      |  |
| Wage Rate       Day       Month       # Days WorkedWK       Full Pay for Date of Injury?       Yes       No         Time Employee       AM       Date of Injury       Time       Date of Injury?       Yes       No         Began Work       PM       Date of Injury       Time       AM       Last Work Date       Date Employer Notified       Date Disability         Began Work       PM       Date of Injury       Time       Occurred       PM       Last Work Date       Date Employer Notified       Date Disability         Began       Work       PM       Date of Injury       Time       Part of Body Affected       Date Disability         Began       Uid Injury/Illness Exposure Occur on Employer's       Yes       Part of Body Affected Code       Part of Body Affected Code         Did Injury/Illness       Employee Engaged in at Time of Occurrence       Work Process the Employee Was Engaged in at Time of Occurrence       All Equipment, Materials, or Chemicals Employee Using upon Occurrence         How injury or illness/abnormal health condition occurred.       Describe the sequence of events and include any objects or substances       Cause of Injury         Date Returned to Work       If Fatal, Date of Death       Were Safeguards or Safety Equipment Provider?       Yes       No         Physician/Health Care Provider (Name & Address)       Hospital (Na  |        |   |  |  |      |  |   | Single/Div.<br>Married Employm |                      | oyment Status              | ient Status                        |                |      |  |
| Wage Rate       Day       Month       # Days WorkedWK       Full Pay for Date of Injury?       Yes       No         Time Employee       AM       Date of Injury       Time       Date of Injury?       Yes       No         Began Work       PM       Date of Injury       Time       AM       Last Work Date       Date Employer Notified       Date Disability         Began Work       PM       Date of Injury       Time       Occurred       PM       Last Work Date       Date Employer Notified       Date Disability         Began       Work       PM       Date of Injury       Time       Part of Body Affected       Date Disability         Began       Uid Injury/Illness Exposure Occur on Employer's       Yes       Part of Body Affected Code       Part of Body Affected Code         Did Injury/Illness       Employee Engaged in at Time of Occurrence       Work Process the Employee Was Engaged in at Time of Occurrence       All Equipment, Materials, or Chemicals Employee Using upon Occurrence         How injury or illness/abnormal health condition occurred.       Describe the sequence of events and include any objects or substances       Cause of Injury         Date Returned to Work       If Fatal, Date of Death       Were Safeguards or Safety Equipment Provider?       Yes       No         Physician/Health Care Provider (Name & Address)       Hospital (Na  | mplc   |   |  |  |      |  |   |                                | NCCI                 | NCCI Class Code            |                                    |                |      |  |
| \$       Week       Other       # Hrs Worked per Day       Did Salary Continue?       Yes       No         Time Employee       AM       Date of Injury       Time       AM       Last Work Date       Date Employer Notified       Date Disability         Began Work       PM       or Illness       Yes       P       P       P       Date of Injury       Part of Body Affected       Date Disability         Began Work       PM       or Illness       Yes       P       P       Part of Body Affected       Date Disability         Began Work       Premises       Yes       Part of Body Affected       Date Disability       Began         Premises?       Yes       Part of Body Affected       Date Disability       Part of Body Affected       Date Disability         Department or location where accident or illness exposure occurred       All Equipment, Materials, or Chemicals Employee Using upon Occurrence       How injury or illness/abnormal health condition occurrence       Work Process the Employee Was Engaged in at Time of Occurrence         How injury or illness/abnormal health condition occurrence       Work Process the Employee Vas Engaged in at Time of Occurrence       No         Date Returned to Work       If Fatal, Date of Death       Were Safeguards or Safety Equipment Provided?       Yes       No         Physician/Health Care Provider (N  |        |   |  |  |      |  |   |                                |                      |                            |                                    |                |      |  |
| Time Employee       AM       Date of Injury       Time       AM       Last Work Date       Date Employer Notified       Date Disability Began         Employer Contact Name/Phone Number       PM       or Illness       Type of Illness/Injury       Part of Body Affected         Did Injury/Illness Exposure Occur on Employer's       Yes       Premises?       Part of Body Affected Code         Department or location where accident or illness exposure occurred       All Equipment, Materials, or Chemicals Employee Using upon Occurrence         How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances       Cause of Injury Code         Date Returned to Work       If Fatal, Date of Death       Were Safeguards or Safety Equipment Provided?       Yes       No         Physician/Health Care Provider (Name & Address)       Hospital (Name & Address)       Initial Treatment       No       No       No         Plate       Signature of Injured Employee, or Signature on File, Date       Witness to Accident (Name & Phone Number)       Signature of Injured Employee, or Signature on File, Date Prepared       Preparer's Name & Title       Preparer's Phone Number   |        |   |  |  |      |  |   |                                |                      |                            |                                    |                |      |  |
| Employer Contact Name/Phone Number       Type of Illness/Injury       Part of Body Affected         Did Injury/Illness Exposure Occur on Employer's       Yes       Part of Body Affected Code         Premises?       No       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       Cause of Injury         Date Returned to Work       If Fatal, Date of Death       Were Safeguards or Safety Equipment Provided?       Yes       No         Physician/Health Care Provider (Name & Address)       Hospital (Name & Address)       Initial Treatment       No Medical Treatment         Upperture       Signature of Injured Employee, or Signature on File, Date       Witness to Accident (Name & Phone Number)       5       Andricipated Major Med/Lost Time         Upperture       Date Administrator Notified       Date Prepared       Preparer's Name & Title       Preparer's Phone Number   |        | Time Employee   |  |  | red  |  |   |                                |                      |                            |                                    |                |      |  |
| Did Injury/Illness Exposure Occur on Employer's       Yes       Part of Body Affected Code         Premises?       No       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       Cause of Injury         Date Returned to Work       If Fatal, Date of Death       Were Safeguards or Safety Equipment Provided?       Yes       No         Physician/Health Care Provider (Name & Address)       Hospital (Name & Address)       Initial Treatment       No Medical Treatment         Minor: By Employee, or Signature on File,       Witness to Accident (Name & Phone Number)       5       Anticipated Major Med/Lost         Date       Date Administrator Notified       Date Prepared       Preparer's Name & Title       Preparer's Phone Number  |        |   |  |  |      |  |   |                                |                      |                            |                                    |                |      |  |
| Premises?       No       Image: Constraint of the second of the s                   |        |   |  |  |      | Type   |   |                                |                      |                            |                                    |                |      |  |
| 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       Cause of Injury<br>Code         Date Returned to Work       If Fatal, Date of Death       Were Safeguards or Safety Equipment Provided?       Yes       No         Physician/Health Care Provider (Name & Address)       Hospital (Name & Address)       Initial Treatment<br>No Medical Treatment<br>Ninor: By Employer<br>Berregency Care       No         Signature of Injured Employee, or Signature on File,<br>Date       Witness to Accident (Name & Phone Number)       5       Anticipated Major Med/Lost<br>Time         Date Administrator Notified       Date Prepared       Preparer's Name & Title       Preparer's Phone Number   | e      | Premises?   |  |  |      | -  |   |                                |                      |                            |                                    |                |      |  |
| 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       Cause of Injury<br>Code         Date Returned to Work       If Fatal, Date of Death       Were Safeguards or Safety Equipment Provided?       Yes       No         Physician/Health Care Provider (Name & Address)       Hospital (Name & Address)       Initial Treatment<br>No Medical Treatment<br>Ninor: By Employer<br>Berregency Care       No         Signature of Injured Employee, or Signature on File,<br>Date       Witness to Accident (Name & Phone Number)       5       Anticipated Major Med/Lost<br>Time         Date Administrator Notified       Date Prepared       Preparer's Name & Title       Preparer's Phone Number   | urreno | Department or location where accident or illness exposure occurred  |  |  |      |  | All Equipment, Materials, or Chemicals Employee Using upon Occurrence |                                |                      |                            |                                    |                |      |  |
| How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances       Cause of Injury<br>Code         Date Returned to Work       If Fatal, Date of Death       Were Safeguards or Safety Equipment Provided?       Yes       No         Physician/Health Care Provider (Name & Address)       Hospital (Name & Address)       Initial Treatment       No Medical Treatment         Minor: By Employee       3       Emergency Care       Hospitalized – 24 hr.         Anticipated Major Med/Lost       Time       Time       Anticipated Major Med/Lost         Date Administrator Notified       Date Prepared       Preparer's Name & Title       Preparer's Phone Number   |        |   |  |  |      | Work Process the Employee Was Engaged in at Time of Occurrence |   |                                |                      |                            |                                    |                |      |  |
| Date Returned to Work       If Fatal, Date of Death       Were Safeguards or Safety Equipment Provided?       Yes       No         Physician/Health Care Provider (Name & Address)       Hospital (Name & Address)       Initial Treatment       No Medical Treatment         Physician/Health Care Provider (Name & Address)       Hospital (Name & Address)       Initial Treatment       No Medical Treatment         Minor: By Employer       3       Emergency Care       Hospitalized – 24 hr.         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  |        |   |  |  |      |  | uence of events and include any objects or substances Cause of Injury |                                |                      |                            |                                    |                |      |  |
| Were they used?       Initial Treatment         Vere they used?       No         Physician/Health Care Provider (Name & Address)       Hospital (Name & Address)       Initial Treatment         No       Medical Treatment       No         No       Medical Treatment       Minor: By Employer         2       Minor Clinic/Hosp       Emergency Care         3       Emergency Care       Hospitalized – 24 hr.         Anticipated Major Med/Lost       Time         Date Administrator Notified       Date Prepared       Preparer's Name & Title       Preparer's Phone Number  |        | that directly injured the employee or made the employee ill.  |  |  |      |  | Code  |                                |                      |                            |                                    |                |      |  |
| 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       Hospital emergency Care         4       Hospitalized – 24 hr.         Anticipated Major Med/Lost       Time         0       Date Administrator Notified       Date Prepared         Preparer's Name & Title       Preparer's Phone Number  |        | Date Returned to Work If Fatal, Date of Deat  |  |  |      |  | -   |                                |                      | Safety Equipment Provided? |                                    |                |      |  |
| A       A       Anticipated – 24 hr.         Signature of Injured Employee, or Signature on File,<br>Date       Witness to Accident (Name & Phone Number)       5       Anticipated Major Med/Lost<br>Time         Date       Date Administrator Notified       Date Prepared       Preparer's Name & Title       Preparer's Phone Number   | Jt     | Physician/Health Care Provider (Name & Address) Hospital (Name  |  |  |      |  |   | e & Address)                   |                      |                            |                                    | Initial Treatr | ment |  |
| A       A       Anticipated – 24 hr.         Signature of Injured Employee, or Signature on File,<br>Date       Witness to Accident (Name & Phone Number)       5       Anticipated Major Med/Lost<br>Time         Date       Date Administrator Notified       Date Prepared       Preparer's Name & Title       Preparer's Phone Number   | atmei  |   |  |  |      |  |   |                                |                      | 1 🔲 Mino                   |                                    | or: By Empl    | oyer |  |
| Signature of Injured Employee, or Signature on File,<br>Date       Witness to Accident (Name & Phone Number)       5       Anticipated Major Med/Lost<br>Time         O       Date Administrator Notified       Date Prepared       Preparer's Name & Title       Preparer's Phone Number   | Tre    |   |  |  |      |  |   |                                |                      |                            | 3 🔲 Eme                            | ergency Car    | e    |  |
| Date Administrator Notified     Date Prepared     Preparer's Name & Title     Preparer's Phone Number   |        | 5 , I , I , I , I , I , I , I , I , I ,   |  |  |      |  |   | lame & Pho                     | one Num              |                            | 5 🔲 Anti                           | cipated Maj    |      |  |
|   | Other  |   |  |  |      | r's Nam  | ne & Tit  | & Title                        |                      |                            |                                    |                |      |  |
|   |        | ling this report is not an admission of liability. This report shall not be evidence of any fact stated herein in any proceeding in r |  |  |      |  |   |                                |                      |                            |                                    |                |      |  |

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)