

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

G E N E R A L	EMPLOYER (NAME & ADDRESS INCLUDE. ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER				REPORT PURPOSE CODE								
			JURISDICTION		JURISDICTION CLAIM NUMBER										
			INSURED REPORT NUMBER												
	SIC CODE		EMPLOYER FEIN		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)			LOCATION #							
							PHONE #								
C L A I M S	CARRIER (NAME, ADDRESS & PHONE NO.)		POLICY PERIOD		CLAIMS ADMIN. (NAME, ADDRESS & PHONE NO.)										
			TO												
			<input type="checkbox"/> CHECK IF SELF INSURED												
A D M I N	CARRIER FEIN		POLICY NUMBER OR SELF-INSURED NUMBER				ADMINISTRATOR FEIN								
	AGENT NAME & CODE NUMBER														
E M P L O Y E E	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"/> UNMARRIED/ SINGLE/DIVORCED		EMPLOYMENT STATUS								
			<input type="checkbox"/> FEMALE		<input type="checkbox"/> MARRIED										
			<input type="checkbox"/> UNKNOWN		<input type="checkbox"/> SEPARATED										
PHONE		# OF DEPENDENTS		<input type="checkbox"/> UNKNOWN		NCCI CLASS CODE									
WAGE RATE PER:		<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:			DID SALARY CONTINUE?		<input type="checkbox"/> YES <input type="checkbox"/> NO							
O C C U R R E N C E	TIME EMPLOYEE BEGAN WORK		<input type="checkbox"/> AM	DATE OF INJURY/ILLNESS		TIME OCCURRED		<input type="checkbox"/> AM	LAST WORK DATE		DATE EMPLOYER NOTIFIED		DATE DISABILITY BEGAN		
			<input type="checkbox"/> PM					<input type="checkbox"/> PM							
	EMPLOYER CONTACT NAME/PHONE NUMBER						TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED					
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?						YES <input type="checkbox"/> NO <input type="checkbox"/>		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 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	
T R E A T M E N T	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 HRS							
								5 ANTICIPATED MAJOR MED/LOST TIME							
O T H E R	SIGNATURE OF INJURED EMPLOYEE, OR SIGNATURE ON FILE:				WITNESS TO ACCIDENT (NAME & PHONE NUMBER)										
	DATE														
DATE ADMINISTRATOR NOTIFIED			DATE PREPARED		PREPARER'S NAME & TITLE				PREPARER'S PHONE NUMBER						