

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.									
NAICS Code				Employer FEIN				Phone No.								
Carrier/Claims Admin	Carrier (Name, Address & Phone Number)				Policy Period		Claims Admin (Name, Address & Phone Number)									
					To											
	<input type="checkbox"/>		Check if self insured													
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		Marital Status		Occupation/Job Title								
				<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Unmarried/Single/Div.	<input type="checkbox"/> Married									
				<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Separated	Employment Status									
	Phone			No. of Dependents		<input type="checkbox"/> Unknown	NCCI Class Code									
	Wage Rate \$		<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	# Days Worked/WK		# Hrs Worked per Day		Full Pay for Date of Injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Did Salary Continue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Occurrence	Time Employee Began Work		<input type="checkbox"/> AM	<input type="checkbox"/> PM	Date of Injury or Illness		Time Occurred		<input type="checkbox"/> AM	<input type="checkbox"/> 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 <input type="checkbox"/>	No <input type="checkbox"/>	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?				<input type="checkbox"/> Yes	<input type="checkbox"/> No				
				Were they used?				<input type="checkbox"/> Yes	<input type="checkbox"/> No							
Treatment	Physician/Health Care Provider (Name & Address)				Hospital (Name & Address)				Initial Treatment							
									0 <input type="checkbox"/>	No Medical Treatment						
								1 <input type="checkbox"/>	Minor: By Employer							
								2 <input 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							
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							

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)

Instructions for Filling Out the Workers' Compensation First Report of Injury or Illness (IC1A-1)

- 1) The form should be filled out by the employer or a representative; however, the injured employee may fill out the form if necessary.
- 2) Fill out non-shaded areas as completely as possible.
- 3) Distribute copies of the completed form as follows:
 - The original to:
Idaho Industrial Commission
PO Box 83720
Boise, ID 83720-0041
(If the form is completed by the injured employee, an additional copy should be sent to the Idaho Industrial Commission. The Idaho Industrial Commission will then send a copy to the adjuster.) **The PDF can be emailed to the Commission; however, you must fill out the form, save it under a different name, and then send as an email attachment to froi@iic.idaho.gov.**
 - One copy to the employer's workers' compensation insurer or adjuster.
 - One copy retained for the employer's files.
- 4) The Idaho Industrial Commission will be happy to answer your questions or provide you with helpful brochures on Facts for Injured Workers and Guides for Employers. To obtain this service, please contact the Idaho Industrial Commission at (208) 334-6000; or you may access many of these brochures on these web pages.

TO THE EMPLOYER: THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE UPON YOUR PREMISES.

NOTICE

REGARDING WORKERS' COMPENSATION INSURANCE

ALL WORKERS EMPLOYED BY THE UNDERSIGNED ARE HEREBY NOTIFIED THAT THE EMPLOYER HAS COMPLIED WITH THE LAW AS TO SECURING THE PAYMENT OF COMPENSATION TO EMPLOYEES AND THEIR DEPENDENTS, IN ACCORDANCE WITH THE PROVISIONS OF THE WORKERS' COMPENSATION LAW.

Employer

Date

By

Employer's Authorized Agent

An employee receiving an injury by accident must immediately notify his/her supervisor, superintendent, or the undersigned, who will provide medical attendance.

Claim for compensation must be made in writing and given to the employer. Forms for giving notice of injury and making claim for compensation will be furnished by the employer; by the surety,

or upon application, by the Industrial Commission in Boise, Idaho.