

# WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG CASE #	REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE	EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR				
CARRIER (NAME, ADDRESS & PHONE #)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)	
		TO		
		CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE		
CARRIER FEIN	POLICY/SELF-INSURED NUMBER			ADMINISTRATOR FEIN

EMPLOYEE/WAGE									
NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH	SOCIAL SECURITY NUMBER		DATE HIRED	STATE OF HIRE		
ADDRESS (INCL ZIP)			SEX	MARITAL STATUS		OCCUPATION/JOB TITLE			
			M MALE	U UNMARRIED SINGLE/DIVORCED					
			F FEMALE	M MARRIED	EMPLOYMENT STATUS				
			U UNKNOWN	S SEPARATED					
PHONE			# OF DEPENDENTS	K UNKNOWN	NCCI CLASS CODE				
RATE PER:	DAY	MONTH	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		YES	NO	
	WEEK	OTHER:			DID SALARY CONTINUE?		YES	NO	

OCCURRENCE/TREATMENT									
TIME EMPLOYEE BEGAN WORK	AM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN		
	PM		( ) CANNOT BE DETERMINED	PM					
CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED		
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?				TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE		
<input type="checkbox"/> YES <input type="checkbox"/> NO									
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED					ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED					WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
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 RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	YES	NO
		WERE THEY USED?	YES	NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFF SITE TREATMENT(NAME & ADDRESS)		INITIAL TREATMENT
				0 NO MEDICAL TREATMENT
				1 MINOR: BY EMPLOYER
				2 MINOR CLINIC/HOSP
				3 EMERGENCY CARE
				4 HOSPITALIZED>24 HOURS
				5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER				
WITNESSES (NAME & PHONE #)				
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER	

## 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:
  - a. The original to the Idaho Industrial Commission, PO Box 83720, Boise, Idaho 83720-0041. (If the form is completed by the injured employee, an additional copy should be sent to the Industrial Commission. The Commission will then send a copy to the adjuster.)
  - b. One copy to the employer's workers' compensation insurer or adjuster.
  - c. One copy retained for the employer's files.
4. The 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 Industrial Commission at 208-334-6000.

**"ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY."**