

Employee Incident Report Form -

IA-1 WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

← Office to Complete →

General	Employer (Name & Address incl. zip)				Carrier/Administrator Claim Number		Report Purpose Code					
					Jurisdiction		Jurisdiction Claim Number					
	Sic Code				Employer FEIN							
					Insured Report Number							
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/Wage	Legal Name (Last, First, Middle)			Date of Birth		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/Div.		Employment Status				
				<input type="checkbox"/> Female		<input type="checkbox"/> Married						
	Phone			No. of Dependents		<input type="checkbox"/> Unknown		NCCI Class Code				
Wage Rate			<input type="checkbox"/> Day		<input type="checkbox"/> Month		# Days Worked/WK		Full Pay for Date of Injury?			
\$ X N/A			<input type="checkbox"/> Week		<input type="checkbox"/> Other		# Hrs Worked per Day		Did Salary Continue?			
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 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		
										Do Not Complete		
Date Returned to Work				If Fatal, Date of Death				Were Safeguards or Safety Equipment Provided?				
								<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No				
Physician/Health Care Provider (Name & Address)						Hospital (Name & Address)						
Witness to Accident (Name & Phone Number)						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"/> Future Major Medical/Lost Time Anticipated						
Date Administrator Notified				Date Prepared		Preparer's Name & Title				Preparer's Phone Number		
IA-1 (2/95) Please sign →												