Iowa Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS **Jurisdiction Code_____** **Jurisdiction Claim Number_____**

CLAIM ADMIN

Claim Administrator Name:	Claim Representative Business Phone Number:	Insurer Name (if different than claim administrator):
Mailing Address, City, State, & Postal Code:	Claim Administrator Claim Number:	Insurer FEIN:
	Claim Administrator FEIN:	Claim Type Code:

EMPLOYER

Employer Name:	Employer FEIN:	Insured Report Number:	Employer Type Code: __ Employer (E) __ Lessor (L)
Physical Address, City, State, & Postal Code:	Mailing Address, City, State, & Postal Code:	Industry Code:	
		Insured Location Number:	Employer UI Number:
Nature of Business:	Employer Contact Name and Business Phone Number:		

POLICY

Insured Name (parent company if different than employer):	Insured FEIN:	Insured Postal Code:	Policy/Contract Number:	Coverage Effective Date: Coverage Expiration Date:	Self Insurance License/ Certificate Number:

EMPLOYEE

Employee Name (First, Middle, Last, & Suffix):	Date of Birth:	Gender: __ Male (M) __ Female (F)	Tax Filing Status (check one): ____ Single (A) ____ Single/Head of Household (B) ____ Married/Filing Joint (C) ____ Married/Filing Separate(D)	
Mailing Address, City, State, & Postal Code:	Date of Hire:	Educational Level (grade completed): _____ [GED = 12]		Marital Status: (check one) ___ Unmarried (U) ___ Married (M) ___ Separated (S)
Phone Number (include area code):	Employment Status (check one): ____ Piece Worker ____ Volunteer ____ Seasonal ____ Apprenticeship/Full-Time ____ Apprenticeship/Part-Time ____ Regular Employee/Full-Time ____ Part-Time ____ Other	Employee ID Number (check one): ID # _____ ____ Social Security Number ____ Employment VISA Number ____ Passport Number ____ Green Card ____ Employee ID Assigned by Jurisdiction		Employee's Authorization to Release the Following: Medical Records __ yes __ no Social Security Number __ yes __ no
Occupation Description:				
Manual Classification Code:				
Department Where Regularly Worked:				

WAGE

Average Wage $ _____ (check one): ___ hourly ___ daily ___ semi-monthly ___ monthly ___ bi-weekly ___ annual ___ weekly	Salary Continued In Lieu of Compensation: ___ yes ___ no	Employee Number of Dependents: _____
	Full Wages Paid for Date of Injury: ___ yes ___ no	Employee Number of Exemptions: _____ (check one) ___ Entitled ___ Withholding
Number of Days Regularly Worked Per Week: _____	Discontinued Fringe Benefits: $_____	

ACCIDENT/INJURY

_____ Date of Injury _____ Date Employer Had Knowledge of the Injury _____ Date Claim Administrator Had Knowledge of the Injury _____ Initial Date Last Day Worked _____ Initial Return to Work Date (if applicable) _____ Employee Date of Death (if applicable)	Describe the nature of the injury. (ex. amputation, burn, cut, fracture):
_____ Time of Injury _____ Time Employee Began Work	Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):
Pre-Existing Disability Code: ___ Yes ___ No ___ Unknown	Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):
Accident Premises Code: ___ Employer (E) ___ Lessee (L) ___ Other (X)	Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):
Accident Site Organization Name:	
Accident Site Street, City, State, & Postal Code:	Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties:
Accident Location Narrative (if no street address):	
Accident Site County/Parish:	Witness Name & Business Phone Number:

MEDICAL

Initial Treatment Code (check one): ___ no medical treatment (0) ___ minor/on-site treatment (1) ___ clinic/hospital visit (2) ___ emergency care (3) ___ hospitalization > 24 hours (4) ___ future medical treatment/lost time anticipated (5)	Initial Medical Provider Name:	Managed Care Organization Name or ID Number:
	Initial Medical Provider Physical Address, City, State, & Postal Code:	ICD Primary Diagnostic Code (if known):

Preparer's Name & Title:	Preparer's Company Name:	Phone Number:	Date:

Instructions for Completing the Iowa First Report of Injury

GENERAL INFORMATION

- ***Dates*** - Enter all dates in MM/DD/CCYY format.
- ***Addresses*** - Enter street address, city, state and postal code (9 digits, if known).
- ***Names*** - Enter all names first name, middle initial, last name, and last name suffix (Jr., Sr., etc., if applicable).
- ***FEIN's*** - Enter the Federal Employer Identification Number of the entity.
- ***Phone Numbers*** - Enter the area code and telephone number (include extension, if applicable).
- ***Employee*** - The individual about whom this form is being filed.
- ***Jurisdiction Code*** – Please use "IA" or "19" to represent the codes used for Iowa.
- ***Jurisdiction Claim #*** - The number assigned by the jurisdiction to identify this claim.
- ***Claim Type Code*** - Enter one of the following codes which represents the current benefit classification of the claim according to jurisdictional requirements:

M	Medical only	**I**	Indemnity	**N**	Notification only
B	Became medical only	**L**	Became lost time	**T**	Transfer (claim jurisdiction changed)

CLAIM ADMINISTRATOR:

- ***Claim Administrator Name*** - Enter the name of the carrier, third party administrator, or self-insured responsible for administering the claim. (Refers to question 8 on prior Iowa form).
- ***Claim Administrator Claim #*** - An identifier which distinguishes a specific claim within a claim administrator's claims processing system assigned by the claim administrator.
- ***Insurer Name*** - The legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim.

EMPLOYER:

- ***Physical Address*** - Enter the address of the employer's facility where the employee was employed at the time of injury. See Accident Site Information question. (Refers to question 2 on prior Iowa form).
- ***Mailing Address*** – Enter the employer's mailing address. (Refers to question 1 on prior Iowa form).
- ***Employer Contact Name*** - Enter the name of the individual at the employer's premises to be contacted for additional information.
- ***Nature of Business*** - Enter the narrative description of the nature of the employer's business related to the specific business operation for which the employee was employed at the time of injury. (Refers to question 3 on prior Iowa form).
- ***Insured Report Number*** - Enter a number that may be assigned by the insured to identify a specific claim. This may be the OSHA 101 number. If no number is assigned, this may be left blank.
- ***Industry Code*** - The code, which represents the nature of the employer's business which may be found in either the Standard Industrial Classification Manual (SIC) or the North American Industrial Classification System (NAICS).
- ***Employer Type Code*** – A code that indicates whether the employer for whom the employee worked at the time of the injury is a lessor. If the employee is paid directly by the employer, check E. If the employee is paid by a leasing company, check L.
  NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.
- ***Employer UI Number*** - Enter the unemployment insurance number assigned for each employer by the state unemployment agency.
- ***Insured Location Number*** - Enter a code defined by the insured which is used to identify the employer's location of the accident. If there is no number, this should be left blank.

POLICY:

- ***Insured Name*** - Indicate the named entity of the policy. (Refers to question 7 on prior Iowa form).
- ***Policy/Contract Number*** - Enter number identifying the coverage policy in effect for the claim. (Refers to question 52 on prior Iowa form).
- ***Coverage Effective Date*** - Enter the date that the employer's insurance policy or self-insurance license/certificate became effective. (Refers to question 50 on prior Iowa form).
- ***Coverage Expiration Date*** - Enter the date that the employer's insurance policy or self-insurance license/certificate expired. (Refers to question 51 on prior Iowa form).

EMPLOYEE:

- ***Employee Name*** - Indicate the employee's legally recognized name. (Refers to question 9 on prior Iowa form).
- ***Occupation Description*** - Indicate the primary occupation of the employee at the time of the accident or injurious exposure. (Refers to question 14 on prior Iowa form).
- ***Date of Hire*** - Provide the date the employee began his/her employment with the specified employer. If there have been multiple periods of employment, the beginning date of the current employment period should be indicated. (Refers to question 13 on prior Iowa form).
- ***Manual Classification Code*** - Provide the code that corresponds to the primary occupation in which the employee was engaged at the time of accident/injury, or injurious exposure, if known.
- ***Employment Status*** - Indicate the employee's work status at the time of injury. In the event that multiple Employment Status Codes apply to the employee, use the following hierarchy to determine which status, the topmost, to report. (i.e., if employee is a part time seasonal worker, report as seasonal worker.) (Refers to question 42 on prior Iowa form).

  1 **Piece Worker** - the injured employee was paid for employment according to the number of products/services completed or number of trips completed.
  2 **Volunteer** - the injured employee was serving at one's own free will without legal obligation of payment.
  3 **Seasonal** - the injured employee was employed in a position dependent on or controlled by the season of the year.
  4 **Apprenticeship Full-Time** - the injured employee was bound by a legal agreement to work full-time for another in return for instruction in a trade or occupation.

5 **Apprenticeship Part-Time** - the injured employee was bound by a legal agreement to work part-time for another in return for instruction in a trade or occupation.
6 **Regular Employee Full Time** - the injured employee was employed on a full-time basis. (schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time). This status is NOT used when reporting experience for full-time seasonal, volunteer, apprenticeship, or piece workers.
7 **Part-time** - the injured employee was employed on a part-time basis (whose work history in the preceding months shows that the person worked on less than a full- time basis). This status is NOT used when reporting experience for part-time seasonal, volunteer, apprenticeship or piece workers.
8 **Other** - the injured employee had an employment status at the time of injury other than those previously listed.

- ***Marital Status*** - U = Widowed, Divorced, Single, Unmarried. (Refers to question 36 on prior Iowa form).

- ***Tax Filing Status*** - Indicate the employee's federal tax filing status used on the Internal Revenue tax forms.
  NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Employee ID Number*** - SSN is preferred. Critical to matching existing claims. If no SSN, please contact Iowa DWC. (Refers to question 10 on prior Iowa form).

- ***Education level*** - Indicate the highest number of years or equivalency level of formal education completed.
  (High school graduate/GED = 12)

- ***Employee Authorization to Release***: NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.
  Medical - Indicate whether the employee has provided written authorization to release medical records related to the injury.
  SSN - Indicate whether the employee has provided a written authorization to release the employee's Social Security Number.

WAGE:

- ***Salary Continued in Lieu of Compensation*** - The status of whether the employer is currently paying the employee's salary in lieu of compensation caused by a work related injury.

- ***Number of Dependents*** - NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Number of Entitled Exemptions*** - The maximum number of exemptions that the employee is entitled to claim on their annual Federal Income Tax. Exemptions include marital status, maximum exemptions employee can claim (e.g. self, 65 and over, blind, spouse, etc.), number of dependent children, and other dependents. Refer to questions 36 & 37 on prior Iowa form).

- ***Number of Withholding Exemptions*** - The number of exemptions that the employee claims on their withholding information provided to the employer.
- NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Average Wage*** - The employee's pre-injury wage for the wage period as statutorily defined by the jurisdiction. The amount may include commissions, piecework earnings and other forms of income converted to a normal scheduled work wee, plus the estimated value of lodging, food, laundry and other payments in kind, as per jurisdictional requirements. Average wage includes discontinued fringes and concurrent employer wages, if any. It is preferred that hourly wage be calculated into a weekly wage. (Refers to question 38 - 42 on prior Iowa form).

ACCIDENT/INJURY:

- ***Time*** - indicate the time military format 00:00 through 23:59 for:
  - ***of Injury*** (Refers to question 22 on prior Iowa form).
  - ***Employee began work*** (Refers to question 23 on prior Iowa form).

- ***Initial Date Last Day Worked*** - Enter the last day the employee was able to work prior to the original lost time from work due to the occupational injury or disease. This date may be the date of injury or the first date prior to the initial lost time.

- ***Initial Return to Work Date*** - Enter the date following the first disability period on which the employee returned to work.

- ***Accident Premises Code*** - Check the code that indicates the premises on which the accident occurred.

- ***Accident Site Information*** - If accident site is different than the Employer Physical Address, then the accident site address information must be completed. For ease of description, Accident Site Address formatting has been developed. (Refers to question 5 on prior Iowa form).

MEDICAL:

- ***Initial Treatment Code*** - Select one of the six choices listed on the form. The choice should indicate the initial treatment only that the injured worker received immediately after the injury. If none, select "No medical treatment". The intent is to reflect care rendered at the time of reporting. Not anticipated care or severity of injury at the time of initial report.

- ***Initial Medical Provider*** - Name of the physician, clinic, hospital or in house treatment provider at the time of the report. (Refers to question 45-47 on prior Iowa form).

- ***Managed Care Organization Name or ID Number*** – NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Primary ICD Diagnostic Code*** - This is only needed if medical treatment was rendered. The medical provider should determine the selected code. If code is provided, enter the ICD (International Classification of Diagnosis or Disease) code depending on jurisdictional requirements at the time of injury.
  NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.

This section is to provide information valuable in handling this claim.

The Iowa Occupational Safety and Health Act

The following is a summary of the recordkeeping, reporting and posting responsibilities of employers under Iowa's Occupational Safety and Health Act.

RECORDKEEPING REQUIREMENTS

Regulations issued under the Iowa Occupational Safety and Health Act of 1972 require establishments subject to the Act to maintain records of recordable occupational injuries and illness. Such records must consist of: (a) a log and summary of occupational injuries and illnesses and (b) a supplementary record of each occupational injury and illness.

LOG AND SUMMARY OF OCCUPATIONAL INJURIES AND ILLNESSES. Each recordable occupational injury and occupational illness must be entered on a log and summary of cases (0SHA Form No. 200) as early as practicable but no later than six working days after receiving information that a recordable case has occurred. A multi-unit employer may maintain the log and summary of occupational injuries and illnesses at a place other than the establishment if there is a copy of the log and summary available in the establishment complete and current to a date within 45 calendar days. If an equivalent of OSHA Form No 200 is used, such as a printout from data-processing equipment, the information shall be as readable and comprehensible to a person not familiar with the data-processing equipment as the OSHA Form No. 200 itself. Logs must be kept current and retained for 5 years following the end of the calendar year to which they relate.

SUPPLEMENTARY RECORD OF OCCUPATIONAL INJURIES AND ILLNESSES. To supplement the Log and Summary of Occupational Injuries and Illnesses, each employer must have available a record for each occupational injury or illness at each establishment within six working days after receiving information that a recordable case has occurred, OSHA Form No. 101 may be used for this purpose. State of Iowa Form No. 14-0001 [(IAIABC Form 1.2 (12/98)], workers' compensation or other reports are acceptable as records if they contain the information required on OSHA Form No 101. These records must be available in the establishment without delay and at reasonable times for examination by representatives of the Iowa Division of Labor Services, the U.S. Department of Labor and the U.S. Department of Health, Education and Welfare. The records must be maintained for a period of not less than 5 years following the end of the calendar year to which they relate.

ANNUAL SUMMARY. Each employer subject to the recordkeeping requirements must prepare a summary of the occupational injury and illness experience of the employees in each of the employer's establishments at the end of each year based on the information contained in the log and summary of occupational injuries and illnesses for the particular establishment. OSHA Form No. 200 shall be used for this purpose. The summary shall be signed and posted in a place accessible to the employees no later than February 1 and shall remain in place until March 1. For employees who do not report to work at a single establishment, or who do not report to any fixed establishment on a regular basis, employers shall satisfy the posting requirement by presenting or mailing a copy of the annual summary during the month of February to all such employees who receive pay during that month. Summaries must be retained for 5 years following the end of the calendar year to which they relate.

EMPLOYEES NOT IN FIXED ESTABLISHMENTS. Employers of employees engaged in physically dispersed operations such as occur in construction, installation, repair or service activities who do not report to any fixed establishment on a regular basis but are subject to common supervision may satisfy the recordkeeping provisions with respect to such employees by:

(a) Maintaining the required records for each operation or group of operations which is subject to common supervision (field superintendent, field supervision, etc.) in an established central place;

(b) Having the address and telephone number of the central place available at each worksite; and

(c) Having personnel available at the central place during normal business hours to provide information from the records maintained there by telephone and by mail.

(Note: This regulation does not automatically apply to all construction, installation, repair or service activities. If in doubt about applicability to your operations, contact the Iowa Division of Labor Services.)

Records for personnel who do not primarily report or work at a single establishment, and who are generally not supervised in their daily work, such as traveling salespersons, technicians, engineers, etc., shall be maintained at the location from which they are paid or the base from which personnel operate to carry out their activities.

REPORTING REQUIREMENTS

Regulations issued under the Iowa Occupational Safety and Health Act require all employers subject to the Act to report to the Iowa Workers' Compensation Commissioner any occupational injury or illness which temporarily disables an employee for more than three days or which results in permanent total disability, permanent partial disability, or death. The report must be filed electronically in conformity with EDI requirements with the Iowa Division of Workers' Compensation within four days from such event when the injury or illness is alleged by the employee to have been sustained in the course of the employee's employment. A report to the Iowa Division of Workers' Compensation is considered to be a report to the Iowa Division of Labor Services. The Iowa Division of Workers' Compensation shall forward all such reports to the Iowa Division of Labor Services.

In addition, employers must report to the Iowa Labor Commissioner within 8 hours each accident or health hazard that results in one or more fatalities or hospitalization of three or more employees.

Those establishments selected to participate in the annual Occupational Injuries and Illnesses Survey will be required to prepare a report (OSHA Form No 200-S) based on entries contained on the Log and Summary of Occupational Injuries and Illnesses.

POSTING REQUIREMENTS

The Iowa Occupational Safety and Health Act requires that employees be informed of the job safety and health protection provided under the Act. The poster, "Safety and Health Protection on the Job," is to be used for this purpose, and must be posted in a prominent place in the establishment to which the employees usually report to work. The poster briefly states the intent and coverage of the Act and the responsibilities of employers and employees to maintain safe and healthful working conditions.

EMPLOYERS WHO MUST KEEP OSHA RECORDS

Employers with 11 or more employees (at any one time in the previous calendar year) in the following industries must keep OSHA records. The industries are identified by name and by the appropriate Standard Industrial Classification (SIC) code:

- Agriculture, forestry, and fishing (SIC's 01-02 and 07-09)
- Oil and gas extraction (SIC 13 and 1477)
- Construction (SIC's 15-17)
- Manufacturing (SIC's 20-39)
- Transportation and public utilities (SIC's 41-42 and 44-49)
- Wholesale trade (SIC's 50-51)
- Building materials and garden supplies (SIC 52)
- General merchandise and food stores (SIC's 53 and 54)
- Hotels and other lodging places (SIC 70)
- Repair services (SIC's 75 and 76)
- Amusement and recreation services (SIC 79)
- Health services (SIC 80), and
- State and local government (Above SIC 's plus 91-97).

If employers in any of the industries listed above have more than one establishment with combined employment of 11 or more employees, records must be kept for each individual establishment.

All employers, including small employers and those in exempted SIC's, must continue to meet the requirement to report fatalities or multiple (3 or more) hospitalizations and all occupational injuries or occupational illnesses that result in a workers' compensation case.

If an employer is notified in writing by the Bureau of Labor Statistics about having been selected to participate in a statistical survey, such employer, including small employers, and those in exempted SIC's, must maintain a log and summary of all occupational injuries and illnesses for that year. The notification will contain the necessary form and instructions to comply with the survey requirements.

The Iowa Workers' Compensation Act

The following is a summary of the recordkeeping and reporting responsibilities of employers under the Iowa Workers' Compensation Act.

RECORDS AND REPORTS

Every employer shall keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day. An employer with notice or knowledge of an injury which temporarily disables an employee for more than three (3) days or results in permanent total disability, permanent partial disability or death is required to electronically file a report with the Workers' Compensation Commissioner within four (4) days from such event when such injury is alleged by the employee to have been sustained in the course of employment.

All books, records, and payrolls of an employer are required to be open for inspection by the Workers' Compensation Commissioner for purposes of administration of the Iowa Workers' Compensation Act.

The Workers' Compensation Commissioner may require an employer to appear and show cause why the employer should not be subject to a civil penalty of $1,000.00 per occurrence for failure to comply with the reporting or inspection requirements. Upon hearing, if the facts indicate, the commissioner may enter an order requiring payment of such penalty. Unless voluntarily paid, the commissioner may petition the district court for entry of judgment on the order. The employer's insurance carrier shall be responsible in the same manner and to the same extent as the employer when a report of injury has been submitted to the employer's insurance carrier and not filed by them with the Workers' Compensation Commissioner.

The employer is required to furnish to an employee, on request, one statement of earnings, wages, or salary for the year preceding the injury. An employer may be subject to a civil penalty of $1000.00 per offense for refusal to furnish such wage statement.

INSTRUCTIONS

An employer with notice or knowledge of an injury which temporarily disables an employee for more than THREE (3) days or results in permanent total disability, permanent partial disability or death is required to electronically file a first report of injury with the Iowa DIVISION OF WORKERS' COMPENSATION within **FOUR (4)** days from such event when such injury is **alleged** by the employee to have been sustained in the course of the employee's employment. A report to the Iowa DIVISION OF WORKERS' COMPENSATION is considered to also be a report to the Iowa DIVISION OF LABOR SERVICES. The Iowa DIVISION OF WORKERS' COMPENSATION forwards the report to the Iowa Division of Labor Services. Employers should report ALL injuries to their insurance carrier or third party administrator. **ALL REPORTS MUST BE FILLED IN COMPLETELY AND SIGNED. PLEASE TYPE OR PRINT LEGIBLY.**

This form contains all items requested on OSHA form No 101, "Supplementary Record of Occupational Injuries and Illness."

THE INFORMATION PROVIDED WILL BE OPEN FOR PUBLIC INSPECTION UNDER Iowa Code § 22.11.