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

General

Employer (Name & Address incl. zip)

Carrier/Administrator Claim Number | Report Purpose Code

Jurisdiction | Jurisdiction Claim Number

Insured Report Number

Employer's Location Address (if different) | Location No.

Sic Code | Employer FEIN | Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)

Policy Period

To

☐ Check if self insured

Claims Admin (Name, Address & Phone Number)

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 KY

Address (Incl. Zip)

Sex: ☐ Male ☐ Female ☐ Unknown

Marital Status: ☐ Unmarried/ Single/Div. ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

Phone | No. of Dependents | NCCI Class Code

Wage Rate $ ☐ Day ☐ Week ☐ Month ☐ Other

Days Worked/WK

Hrs Worked per Day

Full Pay for Date of Injury? ☐ Yes ☐ No

Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM

Date of Injury or Illness

Time Occurred ☐ AM ☐ 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 ☐ No

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

Date Returned to Work | If Fatal, Date of Death

Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No

Were they used? ☐ Yes ☐ No

Treatment

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 hr.
- 5 ☐ Future Major Medical/Lost Time Anticipated

Other

Witness to Accident (Name & Phone Number)

Date Administrator Notified | Date Prepared | Preparer's Name & Title | Preparer's Phone Number

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Supervisor, Dean, Or Chair Signature & Date: