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	
	☐ 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
	☐ Male	☐ Unmarried/ Single/Div.	
	☐ Female	☐ Married	Employment Status
	☐ Unknown	☐ Separated	
Phone	No. of Dependents	☐ Unknown	NCCI Class Code

Wage Rate			# Days Worked/Wk	Full Pay for Date of Injury?	☐ Yes	☐ No
$	☐ Day ☐ Week	☐ Month ☐ Other	# Hrs. Worked per Day	Did Salary Continue?	☐ Yes	☐ No

Occurrence

Time Employee Began Work	Date of Injury or Illness	Time Occurred	Last Work Date	Date Employer Notified	Date Disability Began
☐ AM ☐ PM		☐ AM ☐ PM			

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 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?	☐ 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.

Other

Signature of Injured Employee, or Signature on File, Date		Witness to Accident (Name & Phone Number)	5 ☐ Anticipated Major Med/Lost Time
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.