

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		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.									
				<input type="checkbox"/> Female		<input type="checkbox"/> Married			Employment Status						
	<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated												
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?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
\$		<input type="checkbox"/> Week		<input type="checkbox"/> Other		# Hrs Worked per Day		Did Salary Continue?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
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					
Date Returned to Work			If Fatal, Date of Death			Were Safeguards or Safety Equipment Provided?				<input type="checkbox"/> Yes <input type="checkbox"/> No					
				Were they used?				<input type="checkbox"/> Yes <input type="checkbox"/> No							
Treatment	Physician/Health Care Provider (Name & Address)				Hospital (Name & Address)				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						
Other	Witness to Accident (Name & Phone Number)														
	Date Administrator Notified			Date Prepared		Preparer's Name & Title				Preparer's Phone Number					
IA-1 (2/95)			SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE												