

# Workers Compensation – First Report of Injury or Illness

State Insurance Fund e-mail form – return as an e-mail attachment to ReportClaim@IdahoSIF.org. Do not mail a copy of a printed form.

Every work injury that requires medical services other than first aid treatment must be reported within **TEN** days after the employer has knowledge of the injury. **Filing this form 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.

<b>E M P L O Y E R</b>	Employer's name: <b>1</b>		Employer status <b>4</b>			
	Address:		<input type="checkbox"/> Sole Proprietor <input type="checkbox"/> LLC <input type="checkbox"/> Public			
	City:	State:	ZIP:	<input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other		
	Phone #:	FAX # :				
	Employer's location address (if different)		Is injured worker a Corporate Officer, Partner, LLC member or Sole Proprietor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Address:		If a Sole Proprietorship, is the injured worker a household member? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	City:	State:	ZIP:			
	Policy number: <b>2</b>		Organization code: <b>3</b>			
<b>E M P L O Y E E</b>	Employee's last name: <b>5</b>		State where hired: <b>6</b>			
	Employee's first name:		Occupation: <b>7</b>			
	Address:		Employment status: <b>8</b>			
	City:	State:	ZIP:	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		
	Phone # :	Social Security # :				
	Date of birth:		Date hired: <b>9</b>			
	Under what class code were wages reported? <b>10</b>		Injury date: <b>11</b>			
	Regular department:	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Other <input type="checkbox"/> Married <input type="checkbox"/> Separated				
<b>W A G E S</b>	Wage rate <b>12</b> \$ per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Other		Hours worked per week:			
	# of days worked per week:	Full pay for the day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did salary continue? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If board, lodging or other advantages furnished in addition to wages, give estimated value per week.		\$			
	If gratuities (tips, etc.) were received in the course of employment, give estimated value per week.		\$			
<b>A C C I D E N T O R I L L N E S S</b>	Place of accident or exposure (address): <b>13</b>		City/State:			
	County:	Did injury/illness occur on the employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Time injury occurred: <b>14</b>	<input type="checkbox"/> AM <input type="checkbox"/> PM	Time employee began work:		<input type="checkbox"/> AM <input type="checkbox"/> PM	
	Date last worked: <b>15a</b>	Date employer notified: <b>16</b>	Date disability began: <b>15b</b>			
	Date returned to work: <b>15c</b>	If fatal, date of death: <b>15d</b>		Injury type (strain, cut, etc.): <b>17</b>		
	Part of body affected:		Body part injured before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Injury reported to (name and phone #) : <b>18</b>					
Equipment, materials, or chemicals employee was using upon occurrence: <b>19</b>						
How injury or illness occurred (Describe the sequence of events. Include objects or substances that directly caused the injury) <b>20</b>						
Was accident caused by the failure of a machine or product? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>21</b>		Was safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If the accident was caused by any person or business other than the injured worker, co-worker or the employer, please identify.		Was it used? <input type="checkbox"/> Yes <input type="checkbox"/> No				
		Were other workers also injured? <input type="checkbox"/> Yes <input type="checkbox"/> No				
		List other workers' names:				
<b>M E D</b>	Physician or hospital (name and address) <b>22</b>		<input type="checkbox"/> No medical treatment <input type="checkbox"/> Minor by employer			
			<input type="checkbox"/> Minor – clinic/hospital <input type="checkbox"/> Emergency care			
		<input type="checkbox"/> Anticipated major med/time loss <input type="checkbox"/> Hospitalized overnight				
Did anyone witness the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide name, phone # :						
Preparer's name and title: <b>23</b>						
Preparer's phone number:			Date prepared:			

**E-mail this as an attachment to ReportClaim@IdahoSIF.org. Employers do not need to e-mail this form to the Industrial Commission. Employers should keep a copy on file.**