First Report of Injury or Illness (FROI)

Submit by one of these methods: Mail to SIF, Idaho Workers' Compensation, PO Box 83720, Boise, ID 83720-0044, upload as an attachment at www.idahosif.org, email as an attachment to reportclaim@idahosif.org, or fax to 208-332-8160

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.

EMPLOYER

Submission type: ☐ New Claim ☐ Revised Claim Claim number (if revised): | Date prepared:

Employer's name:

Address:

City: | State: | ZIP:

Entity Type: ☐ Sole Proprietor ☐ Corporation ☐ LLC ☐ Partnership ☐ Public ☐ Other

Country:

Employer's location address:

Is injured worker a Corporate Officer, Partner, LLC member or Sole Proprietor? ☐ Yes ☐ No

City: | State: | ZIP:

If a Sole Proprietor or LLC, is the injured worker a household member? ☐ Yes ☐ No

Country: | Policy #: | FEIN:

Phone: | Email: | Organization code:

EMPLOYEE

Last name: | Suffix: | State where hired:

First name: | MI: | Occupation:

Address: | Employment status: Select one...

City: | State: | ZIP: | Social Security # or Federal ID#:

Country: | Sex: ☐ Female ☐ Male ☐ Unknown | Fed ID Type: Select one...

Phone: | Date of birth: | Date hired:

Class code wages reported: | W2 Employee: ☐ Yes ☐ No | Injury date:

Regular job/dept.: | Marital Status: Select one... | Personal Email:

WAGES

Wage rate: per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Other… explain:

Hours worked per week: ☐ Steady ☐ Variable | Days worked per week: ☐ Steady ☐ Variable

Full pay for the day of injury: ☐ Yes ☐ No If no, how many hours paid for the day of injury? | Did salary continue? ☐ Yes ☐ No

Comments on hours/days worked:

Avg. weekly value of board (lodging, meals, etc.) received in addition to wages: | Avg. weekly value of gratuities (tips, etc.) received:

ACCIDENT OR EXPOSURE

Place of accident/exposure (address): | City:

State: | ZIP: | County: | Country:

Did injury/illness occur on the employer's premises? ☐ Yes ☐ No | Time of injury: ☐ AM ☐ PM | Time employee began work: ☐ AM ☐ PM

Date last worked: | Date employer notified: | Injury reported to:

Date returned to work: | Date disability began: | If fatal, date of death:

Part(s) of body affected: | Side of body: | Body part injured before: ☐ Yes ☐ No

Injury type (strain, cut, etc):

Equipment, materials, or chemicals employee was using upon occurrence:

How injury or illness occurred:

Was accident caused by the failure of a machine or product? ☐ Yes ☐ No | Was safety equipment provided? ☐ Yes ☐ No Was it used? ☐ Yes ☐ No

Was the accident caused by any person or business other than the injured worker, co-worker, or the employer? ☐ Yes ☐ No Please identify:

Were other workers also injured? ☐ Yes ☐ No List other workers' names:

Witnesses to the accident: (name & phone):

MED

Medical Provider name & address:

☐ No medical treatment ☐ Minor by employer ☐ Minor - clinic/hospital ☐ Emergency Care ☐ Hospitalized overnight

Anticipated major medical/time loss: ☐ Yes ☐ No

PREPARER

Name and title: | Role: ☐ Employer ☐ Injured worker ☐ Insurance Agent ☐ Attorney ☐ Medical Provider

Phone: | Email: | Prefer contact by: ☐ Phone ☐ Email

Do you question the claim? ☐ Yes ☐ No

Comments:

As the employer's representative, SIF will submit the FROI to the Industrial Commission. Keep a copy for your records.