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.

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| 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. | | | | | | | |
| E **M**  **P**  **L**  **O**  **Y**  **E**  **R** | Employer’s name: | | | | | | Employer status |
| Address: | | | | | | Sole Proprietor  LLC  Public |
| City:       State:       ZIP: | | | | | | Partnership  Corporation  Other |
| Phone #:       FAX # : | | | | | | Is injured worker a Corporate Officer, Partner, LLC member or Sole Proprietor?  Yes  No |
| Employer’s location address (if different) | | | | | |
| Address: | | | | | | If a Sole Proprietorship, is the injured worker a household member?  Yes  No |
| City:       State:       ZIP: | | | | | |
| Policy number: | | | | | | Organization code: |
| **E**  **M**  **P**  **L**  **O**  **Y**  **E**  **E** | Employee’s last name:       State where hired | | | | | | State where hired: |
| Employee’s first name: | | | | | | Occupation: |
| Address: | | | | | | Employment status: |
| City:       State:       ZIP: | | | | | | Sex  Female  Male |
| Phone # : | | | | | | Social Security # : |
| Date of birth: | | | | | | Date hired: |
| Under what class code were wages reported? | | | | | | Injury date: |
| Regular department: | | Marital status  Single  Widowed  Other  Married  Separated | | | | |
| **W**  **A**  **G**  **E**  **S** | Wage rate $      per  Hour  Day  Week  Month  Other | | | | | Hours worked per week: | |
| # of days worked per week: | Full pay for the day of injury? Yes  No | | | | Did salary continue?  Yes  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. $ | | | | | | |
| **A**  **C**  **C**  **I**  **D**  **E**  **N**  **T**  **O**  **R**  **I**  **L**  **L**  **N**  **E**  **S**  **S** | Place of accident or exposure (address):       City/State: | | | | | | |
| County:       Did injury/illness occur on the employer’s premises?  Yes  No | | | | | | |
| Time injury occurred:        AM  PM Time employee began work:        AM  PM | | | | | | |
| Date last worked:       Date employer notified:       Date disability began: | | | | | | |
| Date returned to work:       If fatal, date of death:       Injury type (strain, cut, etc.): | | | | | | |
| Part of body affected:       Body part injured before?  Yes  No | | | | | | |
| Injury reported to (name and phone #) : | | | | | | |
| Equipment, materials, or chemicals employee was using upon occurrence: | | | | | | |
| How injury or illness occurred (Describe the sequence of events. Include objects or substances that directly caused the injury) | | | | | | |
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| Was accident caused by the failure of a machine or product?  Yes  No | | | | Was safety equipment provided?  Yes  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?  Yes  No | | |
| Were other workers also injured?  Yes  No | | |
| List other workers’ names: | | |
|  | | |
| **M**  **E**  **D** | Physician or hospital (name and address) | | | No medical treatment  Minor by employer | | | |
| Minor – clinic/hospital  Emergency care | | | |
| Anticipated major med/time loss  Hospitalized overnight | | | |
|  | Did anyone witness the accident?  Yes  No If yes, provide name, phone # : | | | | | | |
| Preparer’s name and title: | | | | | | |
| 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.**

SIF 10/05E (froi-emailform.doc)