

Workers Compensation – First Report of Injury or Illness

Mail to the State Insurance Fund, PO Box 83720, Boise, ID 83720-0044, or fax to 208-332-2171

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:		<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 #:		Is injured worker a Corporate Officer, Partner, LLC member or Sole Proprietor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Employer's location address (if different)				If a Sole Proprietorship, is the injured worker a household member? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address:				
	City:		State:	ZIP:	
Policy number:			Organization code:		
E M P L O Y E E	Employee's last name:		State where hired:		
	Employee's first name:		Occupation:		
	Address:		Employment status:		
	City:	State:	ZIP:	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	
	Phone #:		Social Security #:		
	Date of birth:		Date hired:		
	Under what class code were wages reported?		Injury date:		
	Regular department:		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Other <input type="checkbox"/> Married <input type="checkbox"/> Separated		
W A G E S	Wage rate \$ _____ 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.			\$ _____	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Time injury occurred: <input type="checkbox"/> AM <input type="checkbox"/> PM	Time employee began work:		<input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)				
	Was accident caused by the failure of a machine or product? <input type="checkbox"/> Yes <input type="checkbox"/> No		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:			
M E D	Physician or hospital (name and address)		<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:					
Preparer's phone number:			Date prepared:		

Employers do not need to send this form to the Industrial Commission. Employers should keep a copy on file.