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.

EMPLOYER

Employer's name:	Employer status ☐ Sole Proprietor ☐ LLC ☐ Public ☐ Partnership ☐ Corporation ☐ Other
Address:	
City: State: ZIP:	
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:

EMPLOYEE

Employee's last name:	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

WAGES

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. $		

ACCIDENT OR ILLNESS

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)		

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:

MED

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:

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