

Workers Compensation – First Report of Injury or Illness

State Insurance Fund e-mail form – return as an e-mail attachment to reportclaim@isif.state.id.us. 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.		
E M P L O Y E R	Employer's name: University of Idaho	Employer status
	Address: Human Resource Services	<input type="checkbox"/> Sole Proprietor <input type="checkbox"/> LLC <input checked="" type="checkbox"/> Public
	City: Moscow State: ID ZIP: 83844-4332	<input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other
	Phone #: 208-885-3697 FAX #: 208-885-3602	Is injured worker a Corporate Officer, Partner, LLC member or Sole Proprietor? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Employer's location address (if different)	
	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: 03008-0	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:		

E-mail this as an attachment to reportclaim@isif.state.id.us. Employers *do not* need to e-mail this form to the Industrial Commission. Employers should keep a copy on file.