# 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.**

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: |

**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.**