WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

Name

Address

City | State MD

Zip -

INDUSTRY CODE

EMPLOYER FEIN

CARRIER/ADMINISTRATOR CLAIM | OSHA LOG | REPORT PURPOSE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

Address | ( ) -

PHONE #

City | State MD | Zip - | ( ) -

CARRIER (NAME, ADDRESS, & PHONE #)

Name

Address

City | State MD

Zip - | Phone ( ) -

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

POLICY PERIOD

/ /

TO

/ /

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

Name

Address

City | State MD

Zip - | Phone ( ) -

ADMINISTRATOR FEIN

EMPLOYEE Last Name | Middle

First Name

Address

City | State MD

Zip - | Phone ( ) -

OF DEPENDENTS

DATE OF BIRTH / /

SEX

◯ Male

◯ Female

◯ Unknown

SOCIAL SECURITY - -

MARITAL STATUS

◯ Unmarried Single/Divorced

◯ Married

◯ Separated

◯ Unknown

DATE HIRED / /

STATE OF HIRE MD

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

NCCI CLASS CODE

WAGE

RATE | PER: ◯ Day ◯ Week ◯ Month ◯ Other

DAYS WORKED/WEEK 5

FULL PAY FOR DAY OF INJURY? ◯ Yes ◯ No

DID SALARY CONTINUE? ◯ Yes ◯ No

TIME EMPLOYEE BEGAN : ◯ AM ◯ PM

DATE OF INJURY/ILLNESS / /

TIME OF OCCURRENCE : ◯ AM ◯ PM ◯ Unknown

LAST WORK DATE / /

DATE EMPLOYER NOTIFIED / /

DATE DISABILITY BEGAN / /

CONTACT NAME

CONTACT PHONE ( ) -

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?

◯ Yes ◯ No

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK / /

IF FATAL, GIVE DATE OF DEATH / /

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ◯ Yes ◯ No

WERE THEY USED? ◯ Yes ◯ No

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

Name

Address

City | State MD | -

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

Name

Address

City | State MD | -

INITIAL TREATMENT

☐ NO MEDICAL TREATMENT

☐ MINOR BY EMPLOYER

☐ MINOR CLINIC/HOSP

☐ EMERGENCY CARE

☐ HOSPITALIZED > 24 HOURS

☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESS NAME | PHONE ( ) -

ADMINISTRATOR NOTIFIED / / | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER ( ) -

PREPARER'S EMAIL ID:

FORM IA-1(r 1-1-02) IAIABC 2002