WORKERS COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

GENERAL

1. EMPLOYER (Name & Address Incl. Zip)

CARRIER / ADMINISTRATOR CLAIM NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYERS LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

PHONE #

SIC CODE | EMPLOYER FEIN

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO.)

UTAH SCHOOL BOARDS RISK MANAGEMENT MUTUAL INS. ASSOC.
860 EAST 9085 SOUTH
SANDY, UT 84094
(801) 569-3632

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)

UTAH SCHOOL BOARDS RISK MANAGEMENT MUTUAL INS. ASSOC.
860 EAST 9085 SOUTH
SANDY, UT 84094
(801) 569-3632

CARRIER FEIN: 87-0529711 | POLICY / SELF-INSURED NUMBER | ADMINISTRATOR FEIN: 87-0529711

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
- ☐ M MALE
- ☐ F FEMALE
- ☐ U UNKNOWN

MARITAL STATUS
- ☐ U UNMARRIED SINGLE / DIVORCED
- ☐ M MARRIED
- ☐ S SINGLE
- ☐ K UNKNOWN

OCCUPATION / JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | NCCI CLASS CODE

WAGE

RATE | PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER: | # OF DAYS WORKED / WEEK | FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO | DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY / ILLNESS | TIME OF OCCURRENCE ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME / PHONE NUMBER | 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 OCCURRED

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 THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE 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

TREATMENT

PHYSICIAN / HEALTH CARE PROVIDER (NAMES & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
- 0 NO MEDICAL TREATMENT
- 1 MINOR: BY EMPLOYER
- 2 MINOR CLINIC / HOSP
- 3 EMERGENCY CARE
- 4 HOSPITALIZED > 24 HRS
- 5 FUTURE MAJOR MEDICAL / LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER