IA-1

# WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

## General

Employer (Name & Address incl. zip)

Owen County Board of Education
1600 Hwy 22 East
Owenton, KY 40359
FEIN 61-6001340

Carrier/Administrator Claim Number

Report Purpose Code

Jurisdiction

Jurisdiction Claim Number

Insured Report Number

Employer's Location Address (if different)

Location No.

Phone No.

Sic Code

Employer FEIN

## Carrier/Claims Admin

Carrier (Name, Address & Phone Number)

Liberty Mutual Insurance
PO Box 515099
Los Angeles, CA 90051
800-443-2534

Policy Period

To

☐ Check if self insured

Claims Admin (Name, Address & Phone Number)

Liberty Mutual
PO Box 7170
Indianapolis, IN 46207
800-752-5832

Carrier FEIN

Policy Number or Self-Insured Number: WC 8378037

Administrator FEIN

Agent Name & Code Number

## Employee/Wage

Legal Name (Last, First, Middle)

Date of Birth

Social Security Number

Date Hired

State of Hire

Address (Incl. Zip)

Sex: ☐ Male ☐ Female ☐ Unknown

Marital Status: ☐ Unmarried/Single/Div. ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

Phone

No. of Dependents

NCCI Class Code

Wage Rate $ ☐ Day ☐ Week ☐ Month ☐ Other

# Days Worked/WK

# Hrs Worked per Day

Full Pay for Date of Injury? ☐ Yes ☐ No

Did Salary Continue? ☐ Yes ☐ No

## Occurrence

Time Employee Began Work ☐ AM ☐ PM

Date of Injury or Illness

Time Occurred ☐ AM ☐ PM

Last Work Date

Date Employer Notified

Date Disability Began

Employer Contact Name/Phone Number

Type of Illness/Injury

Part of Body Affected

Did Injury/Illness Exposure Occur on Employer's Premises? Yes ☐ No ☐

Type of Illness/Injury 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 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 Returned to Work

If Fatal, Date of Death

Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No

Were they used? ☐ Yes ☐ No

## Treatment

Physician/Health Care Provider (Name & Address)

Hospital (Name & Address)

Initial Treatment

- 0 ☐ No Medical Treatment
- 1 ☐ Minor: By Employer
- 2 ☐ Minor Clinic/Hosp
- 3 ☐ Emergency Care
- 4 ☐ Hospitalized > 24 hr.
- 5 ☐ Future Major Medical/Lost Time Anticipated

## Other

Witness to Accident (Name & Phone Number)

Date Administrator Notified

Date Prepared

Preparer's Name & Title

Preparer's Phone Number

IA-1 (2/95)

SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE

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## Employee Report of Injury

The purpose of this report is to prevent similar incidents from occurring. It should be completed and signed by the injured worker.

Incident: ☐ Near Miss ☐ Minor Injury ☐ Minor Illness ☐ Major Injury ☐ Major Illness

Incident Date: ______________________________ Time: ____________________ AM/PM

Injured Employee: ____________________________________________________________

Occupation: ________________________________________ Months on this job: ________

**Incident Description**

When did you report the incident and to who?

______________________________________________________________

______________________________________________________________

Did you require medical attention? Yes: __________ No: __________

Location of incident (entrance, loading dock, bathroom, etc.) ____________________

______________________________________________________________

Witness(es)

______________________________________________________________

______________________________________________________________

Describe in detail how the incident occurred and what you were doing when it occurred?

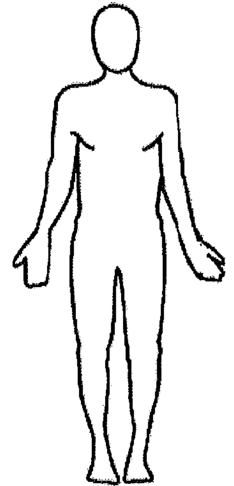
______________________________________________________________

______________________________________________________________

What body part(s) were affected?

______________________________________________________________

______________________________________________________________



Circle Affected Body Part

What unsafe act(s) or condition(s) contributed to the incident?

______________________________________________________________

______________________________________________________________

What is at least one thing that can be done to prevent this type of incident from recurring?

______________________________________________________________

______________________________________________________________

Employee Signature: ________________________________ Date: ____________________

This investigation is being conducted pursuant to the advice of counsel in anticipation of potential litigation. All information and recommendations are confidential.

## Witness Incident Report

The purpose of this report is to prevent similar incidents from occurring. Remember, we are fact finding, not fault finding. Please make this report as accurate and thorough as possible.

Witness Name:______________________________________ Time: ________________ AM/PM

Job Title/Occupation:_______________________________________Work Phone:____________

Incident: ☐ Near Miss ☐ Minor Injury ☐ Minor Illness ☐ Major Injury ☐ Major Illness

Incident Date: _________________________________ Time: ______________________ AM/PM

Injured Employee: ________________________________________________________________

**Incident Description**

Location of incident (entrance, loading dock, bathroom, etc.)__________________

_____________________________________________________________________

Describe in detail how the incident occurred and what the employee was doing when it occurred.

_____________________________________________________________________

_____________________________________________________________________

What unsafe act(s) or condition(s) contributed to the incident?

_____________________________________________________________________

_____________________________________________________________________

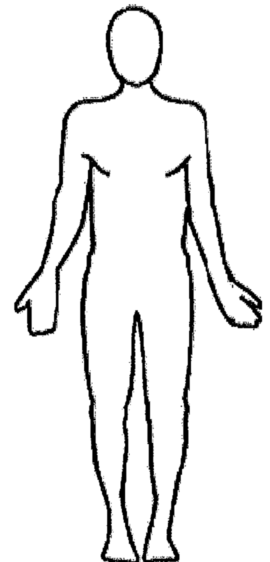
What body part(s) were affected?

_____________________________________________________________________

What is at least one thing that can be done to prevent this type of incident from happening again?

_____________________________________________________________________

_____________________________________________________________________



Circle Affected Body Part

Witness Signature: ______________________________________ Date: ______________________

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