Kentucky First Report of Injury or Illness Form (page 1 of 2)

IA-1 WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)	Carrier/Administrator Claim Number	Report Purpose Code
	Jurisdiction / Jurisdiction Claim Number	
	Insured Report Number	
	Employer's Location Address (if different)	Location No
Sic Code / Employer FEIN		Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)	Policy Period / To / ☐ Check if self insured	Claims Admin (Name, Address & Phone Number)
Carrier FEIN	Policy Number or Self-Insured Number	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	Occupation/Job Title	
Phone	No. of Dependents	☐ Unknown	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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