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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **General** | Employer (Name & Address incl. zip)  GRANT COUNTY BOARD OF EDUCATION  820 ARNIE RISEN BLVD.  WILLIAMSTOWN, KY 41097 | | | | | | | | | | | | | | | 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  61-6001380 | | | | | | | | | | | Phone No. | | | | | | | |
| **Carrier/Claims Admin** | Carrier (Name, Address & Phone Number)  CHURCH MUTUAL  PO Box 2912  Milwaukee, WI 53201-2912 | | | | | | | | | | | | | | | Policy Period | | | | | Claims Admin (Name, Address & Phone Number)  Submit to Brian Linder at Grant County Board of Education. | | | | | | | | | | | | | | |
|  | | | | |
| To | | | | |
|  | | | Check if self insured | |
| Carrier FEIN | | | | Policy Number or Self-Insured Number  07-033006 | | | | | | | | | | | | | | | | Administrator FEIN | | | | | | | | | | | | | | |
| Agent Name & Code Number  CURNEAL & HIGNITE INSURANCE, INC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Employee/Wage** | Legal Name (Last, First, Middle) | | | | | | | Date of Birth | | | | | | Social Security Number | | | | | | Date Hired | | | | | | | State of Hire | | | | | | | | |
| Address (Incl. Zip) | | | | | | | Sex | | | | | | | Marital Status | | | | | Occupation/Job Title | | | | | | | | | | | | | | | |
|  | | | Male | | | |  | | | Unmarried/Single/Div. | |
|  | | | Female | | | |  | | | Married | | Employment Status | | | | | | | | | | | | | | | |
|  | | | Unknown | | | |  | | | Separated | |
| Phone | | | | | | | No. of Dependents | | | | | | |  | | | Unknown | | NCCI Class Code | | | | | | | | | | | | | | | |
| Wage Rate  $ | |  | Day | | | |  | | | Month | | | | # Days Worked/WK | | | | | Full Pay for Date of Injury? | | | | | | | |  | | Yes | |  | | No | |
|  | Week | | | |  | | | Other | | | | # Hrs Worked per Day | | | | | Did Salary Continue? | | | | | | | |  | | Yes | |  | | No | |
| **Occurrence** | Time Employee Began Work |  | AM | Date of Injury or Illness | | | | | Time Occurred | | | | | |  | AM | | | Last Work Date | | | Date Employer Notified | | | | | | | | Date Disability Began | | | | | |
|  | PM |  | PM | | |
| Employer Contact Name/Phone Number  859-824-3323 | | | | | | | | | | | | | | Type of Illness/Injury | | | | | | | | Part of Body Affected | | | | | | | | | | | | |
| Did Injury/Illness Exposure Occur on Employer’s Premises? | | | | | | | | | Yes | | |  | | Type of Illness/Injury Code | | | | | | | | Part of Body Affected Code | | | | | | | | | | | | |
| No | | |  | |
| 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. | | | | | | | | | |
| **Other** | Witness to Accident (Name & Phone Number) | | | | | | | | | | | | | | | | | | | | | | | 5 |  | Future Major Medical/Lost Time Anticipated | | | | | | | | | |
|  | | | | | | | | | | | |
| 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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