

Iowa Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS

Jurisdiction Code \_\_\_\_\_

Jurisdiction Claim Number \_\_\_\_\_

<b>CLAIM ADMIN</b>	Claim Administrator Name:		Claim Representative Business Phone Number:		Insurer Name (if different than claim administrator):	
	Mailing Address, City, State, & Postal Code:		Claim Administrator Claim Number:		Insurer FEIN:	
<b>EMPLOYER</b>	Employer Name:		Employer FEIN:		Insured Report Number:	
	Physical Address, City, State, & Postal Code:		Mailing Address, City, State, & Postal Code:		Industry Code:	
	Nature of Business:		Employer Contact Name and Business Phone Number:		Employer Type Code: ___ Employer (E) ___ Lessor (L)	
					Employer UI Number:	
<b>POLICY</b>	Insured Name (parent company if different than employer):		Insured FEIN:		Insured Postal Code:	
					Policy/Contract Number:	
<b>EMPLOYEE</b>	Employee Name (First, Middle, Last, & Suffix):		Date of Birth:		Gender: ___ Male (M)    ___ Single (A)    ___ Married/Filing Joint (C) ___ Female (F)    ___ Single/Head of Household (B)    ___ Married/Filing Separate(D)	
	Mailing Address, City, State, & Postal Code:		Date of Hire:		Tax Filing Status (check one): ___ Single (A)    ___ Married/Filing Joint (C) ___ Single/Head of Household (B)    ___ Married/Filing Separate(D)	
	Phone Number (include area code):		Employment Status (check one): ___ Piece Worker ___ Volunteer ___ Seasonal ___ Apprenticeship/Full-Time ___ Apprenticeship/Part-Time ___ Regular Employee/Full-Time ___ Part-Time ___ Other		Educational Level (grade completed): _____ [GED = 12]	
	Occupation Description:		Employee ID Number (check one): ID # _____ ___ Social Security Number ___ Employment VISA Number ___ Passport Number ___ Green Card ___ Employee ID Assigned by Jurisdiction		Marital Status: (check one) ___ Unmarried (U) ___ Married (M) ___ Separated (S)	
	Manual Classification Code:				Employee's Authorization to Release the Following: Medical Records    ___ yes    ___ no Social Security Number    ___ yes    ___ no	
	Department Where Regularly Worked:					
<b>WAGE</b>	Average Wage \$ _____ (check one): ___ hourly    ___ daily    ___ semi-monthly    ___ monthly ___ bi-weekly    ___ annual    ___ weekly		Salary Continued In Lieu of Compensation:    ___ yes    ___ no		Employee Number of Dependents: _____	
	Number of Days Regularly Worked Per Week: _____		Full Wages Paid for Date of Injury:    ___ yes    ___ no		Employee Number of Exemptions: _____ (check one) ___ Entitled ___ Withholding	
			Discontinued Fringe Benefits: \$ _____			
<b>ACCIDENT/INJURY</b>	Date of Injury Date Employer Had Knowledge of the Injury Date Claim Administrator Had Knowledge of the Injury Initial Date Last Day Worked Initial Return to Work Date (if applicable) Employee Date of Death (if applicable)		Describe the nature of the injury. (ex. amputation, burn, cut, fracture):			
	Time of Injury Time Employee Began Work		Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):			
	Pre-Existing Disability Code: ___ Yes ___ No ___ Unknown		Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):			
	Accident Premises Code: ___ Employer (E) ___ Lessee (L) ___ Other (X)		Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):			
	Accident Site Organization Name:					
	Accident Site Street, City, State, & Postal Code:					
	Accident Location Narrative (if no street address):		Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties:			
	Accident Site County/Parish:		Witness Name & Business Phone Number:			
<b>MEDICAL</b>	Initial Treatment Code (check one): ___ no medical treatment (0) ___ minor/on-site treatment (1) ___ clinic/hospital visit (2) ___ emergency care (3) ___ hospitalization > 24 hours (4) ___ future medical treatment/lost time anticipated (5)		Initial Medical Provider Name:		Managed Care Organization Name or ID Number:	
			Initial Medical Provider Physical Address, City, State, & Postal Code:		ICD Primary Diagnostic Code (if known):	
Preparer's Name & Title:		Preparer's Company Name:		Phone Number:		
				Date:		

## First Report of Injury or Illness Requirement

A First Report of Injury or Illness (First Report) must be filed by an employer or the employer's insurance carrier in case of occupational

- fatality,
- permanent disability; or,
- temporary disability lasting more than three days.

A First Report must be electronically filed within four days of the incident. An employer or insurance carrier must file a First Report if the employee says the disability is caused by work even if the employer disagrees.

For more information on these and other requirements, please call 515-281-5387 or visit <http://www.iowaworkforce.org/wc/>.

### The Iowa Workers' Compensation Act RECORDS AND REPORTS

**Every employer shall keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day. An employer with notice or knowledge of an injury which temporarily disables an employee for more than three days or results in permanent total disability, permanent partial disability or death is required to electronically file a report with the Workers' Compensation Commissioner within four days from such event when such injury is alleged by the employee to have been sustained in the course of employment.**

All books, records, and payrolls of an employer are required to be open for inspection by the Workers' Compensation Commissioner for purposes of administration of the Iowa Workers' Compensation Act.

The Workers' Compensation Commissioner may require an employer to appear and show why the employer should not be subject to a civil penalty of \$1,000.00 per occurrence for failure to comply with the reporting or inspection requirements. Upon hearing, if the facts indicate, the commissioner may enter an order requiring payment of such penalty. Unless voluntarily paid, the commissioner may petition the district court for entry of judgment on the order. The employer's insurance carrier shall be responsible in the same manner and to the same extent as the employer when a report of injury has been submitted to the employer's insurance carrier and not filed by them with the Workers' Compensation Commissioner.

The employer is required to furnish to an employee, on request, one statement of earnings, wages, or salary for the year preceding the injury. An employer may be subject to a civil penalty of \$1000.00 per offense for refusal to furnish such wage statement.

### Additional Iowa OSHA Reporting Requirements

Additional reporting and recordkeeping requirements may apply to the incident described on the First Report. An employer must:

- Report a workplace fatality to Iowa OSHA within 8 hours. You may report by calling 877-242-6742 or visit [www.iowaosha.gov](http://www.iowaosha.gov) for a form and instructions.
- Report a hospitalization, the loss of any eye, or an amputation to Iowa OSHA within 24 hours. You may report by calling 877-242-6742 or visit [www.iowaosha.gov](http://www.iowaosha.gov) for a form and instructions.
- Complete an OSHA Form 301 or equivalent for recordable, work-related incidents within seven days and retain the completed form on site. The First Report is equivalent to the OSHA Form 301 if the case number from the OSHA 300 log is added. Visit [www.osha.gov/recordkeeping](http://www.osha.gov/recordkeeping) for more information.
- Make an entry in your Log of Work-Related Injuries and Illnesses, OSHA Form 300, for recordable cases within seven days and retain the completed form on site. Some industries are exempt from this requirement. Visit [www.osha.gov/recordkeeping](http://www.osha.gov/recordkeeping) for more information.

For more information on these and other OSHA requirements, please visit [www.iowaosha.gov](http://www.iowaosha.gov) or call 515-242-5870.

