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

EMPLOYER (NAME & ADDRESS INCL ZIP)
Murray State University
Human Resources
404 Sparks Hall
Murray, KY 42071-3312

CARRIER/ADMINISTRATOR CLAIM NUMBER: N/A
REPORT PURPOSE CODE: N/A
JURISDICTION: N/A
JURISDICTION CLAIM NUMBER: N/A
INSURED REPORT NUMBER: N/A
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)
LOCATION # N/A
PHONE#
SIC CODE: N/A
EMPLOYER FEIN: N/A

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO.): N/A
POLICY PERIOD: N/A TO
CHECK IF APPROPRIATE: [X] SELF INSURANCE
CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.): N/A
CARRIER FEIN: N/A
POLICY/SELF-INSURED NUMBER: N/A
ADMINISTRATOR FEIN: N/A
AGENT NAME & CODE NUMBER: N/A

EMPLOYEE/WAGE

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 SEPARATED / K UNKNOWN
OCCUPATION/JOB TITLE
EMPLOYMENT STATUS
PHONE
 # OF DEPENDENTS
NCCI CLASS CODE: N/A
RATE PER: DAY / WEEK / MONTH / OTHER:
#DAYS WORKED/WEEK
FULL PAY FOR DAY OF INJURY? YES / NO
DID SALARY CONTINUE? YES / NO

OCCURRENCE/TREATMENT

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: N/A
PART OF BODY AFFECTED CODE: N/A
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: N/A
DATE RETURN(ED) TO WORK
IF FATAL, GIVE DATE OF DEATH
WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES / NO
WERE THEY USED? YES / NO
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 HRS
- 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESSES (NAME & PHONE #)
Supervisor's Name & Signature

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

IA-1 (2/95)

SEE BACK FOR IMPORTANT STATE INFORMATION/SIGNATURE

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