

| IA-1 WORKER'S COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS | | | | | | | | | | |
|--|---|--|--|--|---|--|---|---|--|--|
| EMPLOYER (NAME & ADDRESS INCL ZIP) Green River District Health Dept P.O. Box 309 1501 Breckenridge St. Owensboro, KY 42302-0309 | | | CARRIER/ADMINISTRATOR CLAIM NUMBER | | | | REPORT PURPOSE CODE | | | |
| SIC CODE 8399 | | | EMPLOYER FEIN | | EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT): 1501 Breckenridge St. Owensboro, KY 42303 | | | | | |
| CARRIER/CLAIMS ADMINISTRATOR | | | | | | | | | | |
| CARRIER (NAME, ADDRESS & PHONE NO.) | | | POLICY PERIOD TO | | | CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.) | | | | |
| CARRIER FEIN | | | POLICY/SELF-INSURED NUMBER | | | | ADMINISTRATOR FEIN | | | |
| AGENT NAME & CODE NUMBER | | | | | | | | | | |
| EMPLOYEE/WAGE | | | | | | | | | | |
| NAME (LAST, FIRST, MIDDLE) | | | DATE OF BIRTH | | SOCIAL SECURITY NUMBER | | DATE HIRED | STATE OF HIRE Kentucky | | |
| 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 | K UNKNOWN | NCCI CLASS CODE | | | | | | |
| RATE PER | DAY WEEK | MONTH | OTHER: Hour | # DAYS WORKED/WEEK 5 | FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE? | | <input checked="" type="checkbox"/> YES | <input type="checkbox"/> NO | <input checked="" type="checkbox"/> YES | <input type="checkbox"/> NO |
| OCCURRENCE/TREATMENT | | | | | | | | | | |
| WORK TIME BEGAN | <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM | DATE OF INJURY/ILLNESS | | TIME OF OCCURRENCE | <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | | DATE DISABILITY BEGAN | |
| CONTACT NAME/PHONE NUMBER Rebecca Baird 270-686-7747 ext 3038 | | | | TYPE OF INJURY/ILLNESS | | | PART OF BODY AFFECTED | | | |
| DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | TYPE OF INJURY/ILLNESS CODE | | | PART OF BODY AFFECTED CODE | | | |
| DEPARTMENT OF LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | | | | | ALL EQUIPMENT, MATERIALS, 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 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 HE EMPLOYEE OR MADE THE EMPLOYEE ILL | | | | | | | | | | |
| DATE RETURN(ED) TO WORK | | | | | | | IF FATAL, GIVE DATE OF DEATH | | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED? | CAUSE OF INJURY CODE |
| | | | | | | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> 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 HOURS | | |
| | | | | | | | | 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED | | |
| DATE ADMINISTRATOR NOTIFIED | | DATE PREPARED | | PREPARER'S NAME & TITLE Rebecca Baird, HR/Risk Assessment | | | | PHONE NUMBER 270-686-7747 ext 5580 | | |