CLEAR FORM

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME &ADDRESS INCL. ZIP)

UNIVERSITY OF LOUISVILLE
2301 SOUTH THIRD STREET
LOUISVILLE, KY 40292

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE NO.)

PMA
P.O. BOX 25248
LEHIGH VALLEY, PA 1800-5248

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO.)

PMA MEDICAL BILLS
P.O. BOX 5321
JANESVILLE, WI 53547-5231

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

Employee ID:

EMPLOYEE/WAGE

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/DIVORCE
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE

PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ HOUR

AVG WEEKLY WAGES

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/ILLNESSEXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS 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 RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFTY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER(NAME & ADDRESS)

Campus Health Services
University of Louisville
401 East Chestnut Street Suite 110
Louisville, KY 40202

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

☐ NO MEDICAL TREATMENT
☐ MINOR: BY EMPLOYER
☐ MINOR CLINIC/HOSP
☐ EMERGENCY CARE
☐ HOSPITALIZED >24 HRS
☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESS (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

Form IA-1

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Applicable in Alaska

A person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception.

Applicable in Arkansas

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding worker's compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

Applicable in California

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying worker's compensation benefits or payments is guilty of a felony.

Applicable in Connecticut

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Applicable in Delaware and Oklahoma

Any person who, knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. * Delaware Statutes Regulation: Del #C Section 913(B)

Applicable in Florida

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company of self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Applicable in Idaho

Any person who, knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company, Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

Applicable in Indiana

A person who, knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kentucky and New York

Any person who, knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Michigan

Any person who, knowingly and with intent to injure or defraud any insurer submits a claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to $5,000.00.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a

fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in New Jersey

Any person who, knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Pennsylvania

Any person who, knowingly and with intent to injure or defraud any insurer files a claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years or payment of a fine of up to $50,000.00.

Applicable in Utah

Any person who, knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

EMPLOYEE SIGNATURE:_____

SUPERVISOR SIGNATURE:_____

OFFICE USE ONLY

University of Louisville
Occupational Injury or Illness Form
IA-1 Supplemental

DEHS OSHA LOG # _____

Attention: a delay in processing may occur if this form is not completed in its entirety

Employee Name	Date of Injury	Employee's work phone number
Employee's Supervisor	Dept. or School	Supervisor's phone number

Please answer the following questions by checking in the column yes or no.	YES	NO
OSHA must be notified of the following incidents. If you answer yes to any of the 3 questions below you must notify DEHS at 852-6670 or DPS at 852-6111as soon as possible.		
• Did the employee require in-patient hospitalization over 24 hours?	◯	◯
• Did the employee suffer any amputation?	◯	◯
• Did the employee die? Date of death:	◯	◯
Did the injury or illness require first aid? If yes, check all that apply		
__ Non-prescription medication __ Negative x-ray or diagnostic test __ Tetanus shot __ Cleaning, flushing wounds __ Using wound coverings such as bandages, band aids or butterfly bandages __ Drilling finger or toe nail	__ Using irrigation or cotton swab to remove foreign bodies not embedded in eye __ Irrigation or tweezers to remove splinters or foreign material from areas other than eye __ Hot or cold therapy __ Drinking fluids for heat stress	__ Draining fluid from blister __ Using massages (physical therapy and chiropractic care are medical treatment) __ Non-rigid support (elastic bandages, wraps) __ Using finger guards __ Appointments solely for observation or counseling
Did the injury require medical treatment? (Any treatment other than first aid listed above)	◯	◯
Did the employee require treatment in an Emergency Room?	◯	◯
Did the employee lose consciousness?	◯	◯
Did the injury or illness result in days away from work? Provide dates employee was away from work.	◯	◯
Did the injury or illness result in restricted work activity or job transfer? Provide dates employee was restricted or transferred or if permanent job transfer	◯	◯
Did the injury result from a needlestick or other sharp contaminated with blood or OPIM? Type of sharp: Sharps Safety Device used:	◯	◯

Please answer questions completely, be as specific as possible

What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from a hand sprayer"; "daily computer keyboard entry"

What happened? Tell us how the injury occurred. Examples: "When the ladder slipped on the wet floor, the worker fell 20 feet"; "worker was spraying with chlorine when the gasket broke during replacement"; Worker developed soreness in wrist over time".

What was the injury or illness? Tell us the part of the body affected and how it was affected. Be more specific than "hurt", "pain" or "sore". Examples: "Scraped and bruised back and lower legs"; "chemical burn to left hand"; carpal tunnel syndrome

What object or substance directly harmed the employee? Tell us if the object or material the employee was using caused the injury or an object in the environment directly harmed the employee. Examples: "the bushes and ground"; "chlorine." If this question does not apply to this incident, indicate N/A.