# WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

**EMPLOYER (NAME &ADDRESS INCL. ZIP)**
UNIVERSITY OF LOUISVILLE

**CARRIER/ADMINISTRATOR CLAIM NUMBER**

**REPORT PURPOSE CODE**

**JURISDICTION**

**JURISDICTION CLAIM NUMBER**

**INSURED REPORT NUMBER**

**EMPLOYER LOCATION ADDRESS (IF DIFFERENT)**
SCHOOL OF EDUCATION

**LOCATION #**

**SIC CODE**

**EMPLOYER FEIN**

**PHONE #** 852-XXXX

## CARRIER/CLAIMS ADMINISTRATOR

**CARRIER (NAME, ADDRESS, & PHONE NO.)**

**POLICY PERIOD**
TO

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

**CHECK IF APPROPRIATE**
[ ] SELF INSURANCE

**CARRIER FEIN**

**POLICY/SELF-INSURED NUMBER**

**ADMINISTRATOR FEIN**

**AGENT NAME & CODE NUMBER**

## EMPLOYEE/WAGE

**NAME (LAST, FIRST, MIDDLE)**
JONES, JAN J

**DATE OF BIRTH**
1/1/71

**SOCIAL SECURITY NUMBER**
XXX-XX-XXXX

**DATE HIRED**
1/1/81

**STATE OF HIRE**
KENTUCKY

**ADDRESS (INCL. ZIP)**
XXX STREET NAME
CITY, STATE ZIP

**SEX**
[ ] MALE
[X] FEMALE
[ ] UNKNOWN

**MARITAL STATUS**
[ ] UNMARRIED
[ ] SINGLE/DIVORCE
[X] MARRIED
[ ] SEPARATED
[ ] UNKNOWN

**OCCUPATION/JOB TITLE**
UNIT BUSINESS MANAGER

**EMPLOYMENT STATUS**
FULL TIME

**PHONE**
502-XXX-XXXX

**# OF DEPENDENTS**
2

**NCCI CLASS CODE**

**RATE**
12.00

**PER:** [ ] DAY [ ] WEEK [ ] MONTH [X] HOUR

**AVG WEEKLY WAGES**
450.00

**# DAYS WORKED/WEEK**
5/37.5

**FULL PAY FOR DAY OF INJURY?** [X] YES [ ] NO

**DID SALARY CONTINUE?** [ ] YES [ ] NO

## OCCURRENCE/TREATMENT

**TIME EMPLOYEE BEGAN WORK**
8:00 [X] AM [ ] PM

**DATE OF INJURY/ILLNESS**
1/1/2006

**TIME OF OCCURRENCE**
8:25 [X] AM [ ] PM

**LAST WORK DATE**
1/1/2006

**DATE EMPLOYER NOTIFIED**
1/1/2006

**DATE DISABILITY BEGAN**

**CONTACT NAME/PHONE NUMBER**
SALLY SUE SUPERVISOR/852-XXXX

**TYPE OF INJURY/ILLNESS**
FALL

**PART OF BODY AFFECTED**
RIGHT LEG

**DID INJURY/ILLNESSEXPOSURE OCCUR ON EMPLOYER'S PREMISES?**
[X] YES [ ] NO

**TYPE OF INJURY/ILLNESS CODE**

**PART OF BODY AFFECTED CODE**

**DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED**
SCHOOL OF EDUCATION
1ST FLOOR HALLWAY

**ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED**
N/A

**SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED**
WALKING TO FILE ROOM

**WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED**
FILING

**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**
TRIPPED OVER FILES IN FLOOR

**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)**
DOCTOR WHO

**HOSPITAL (NAME & ADDRESS)**
U OF L HOSPITAL

**INITIAL TREATMENT**
[X] NO MEDICAL TREATMENT
[ ] MINOR: BY EMPLOYER
[ ] MINOR CLINIC/HOSP
[ ] EMERGENCY CARE
[ ] HOSPITALIZED >24 HRS
[ ] FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

**WITNESS (NAME & PHONE #)**
N/A

**DATE ADMINISTRATOR NOTIFIED**
1/1/2006

**DATE PREPARED**
1/1/2006

**PREPARER'S NAME & TITLE**
SALLY SUE (SIGNATURE), SUPERVISOR

**PHONE NUMBER**
852-XXXX

**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:_____