# WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL. ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #: | PHONE #:

SIC CODE | EMPLOYER FEIN

## CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO.)

**AMFED CASUALTY INSURANCE COMPANY**
P.O. Box 1380
Ridgeland, MS 39158-1380
(601) 853-4949 Fax: (601) 853-2727

POLICY PERIOD
TO

CHECK IF APPROPRIATE
☐ SELF INSURANCE

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 **MS**

ADDRESS (INCL. ZIP)

SEX
M MALE
F FEMALE
U UNKNOWN

MARITAL STATUS
U UNMARRIED SINGLE/DIVORCED
M MARRIED
S SEPARATE4D
K UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

NCCI CLASS CODE

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 | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIAL, 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 SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO | WHERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDED (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 |

WITNESS (NAME & PHONE#)

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

IAIABC IA-1 (10/93)

**SEE BACK FOR INSTRUCTIONS**

# EMPLOYER'S INSTRUCTIONS

## DO NOT ENTER DATA IN SHADED FIELDS

DATES:
Enter all dates in MM/DD/YY format.

SIC CODE:
This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

CARRIER:
The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of claimant.

CLAIMS ADMINISTRATOR:
Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:
Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:
This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:
Indicate the employee's work status. The vaild choices are:

| | | | |
|---|---|---|---|
| Full-Time | On Strike | Unknown | Volunteer |
| Part-time | Disabled | Apprenticeship Full-Time | Seasonal |
| Not Employed | Retired | Apprenticeship Part-Time | Piece Worker |

DATE DISABILITY BEGAN:
The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwise deigned by statute.

CONTACT NAME/PHONE NUMBER:
Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:
Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF THE BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURED:
(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210).

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occured. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCES THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURED:
Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

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:
(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED): TO WORK:
Enter the date following the most recent disability period on which the employee returned to work.

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Any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under this chapter (Mississippi Worker's Compensation Law) is guilty of a felony and on conviction thereof may be punished by a fine not to exceed Five Thousand Dollars ($5,000.00) or double the value of the fraud, whichever is greater, or by imprisionment not to exceed three (3) years, or by both fine and imprisonment.

**NOTE TO SUPERVISOR**

REMEMBER AN ACCIDENT INVESTIGATION IS NOT DESIGNED TO FIND FAULT OR BLAME. IT IS AN ANALYSIS TO DETERMINE CAUSES THAT CAN BE CONTROLLED OR ELIMINATED.

**WHEN COMPLETING THE INVESTIGATION, TRY TO ANSWER THESE QUESTIONS**

HOW DID THE ACCIDENT OCCUR?

WHERE DID IT HAPPEN?

WHAT MATERIAL, MACHINES EQUIPMENT OR CONDITIONS WERE INVOLVED

WHO WAS INJURED?

WHEN DID IT HAPPEN?

MAKE RECOMMENDATIONS!

NO INVESTIGATION IS COMPLETE UNLESS CORRECTIVE ACTION IS SUGGESTED

FOLLOW-UP

DETERMINE WHAT ACTION IS BEING TAKEN ON YOUR RECOMMENDATIONS.

## SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

DATE _____ TIME _____

EMPLOYEE INVOLVED _____ AGE _____

POSITION _____ DATE EMPLOYED _____

SUPERVISOR _____ DEPARTMENT _____

HOW LONG WAS EMPLOYEE PREFORMING THIS OPERATION? _____

WAS THE EMPLOYEE INSTRUCTED _____

DID THE ACCIDENT RESULT IN AN INJURY _____

NATURE AND EXTENT OF INJURY

DATE INJURY REPORTED _____ LOSS OF WORK DAYS _____ (YES OR NO)

IF SO WHEN, AND BY WHOM _____

HOW DID ACCIDENT OCCUR?

CAUSE OF ACCIDEN

RECOMMENDATIONS TO PREVENT A RECURRENCE

WHAT ACTION HAS BEEN TAKEN

**SIGNED** _____ **DEPT** _____ **DATE** _____

**SAFETY COMMITTEE COMMENTS**

RECOMMENDATIONS

SIGNED _____ DEPT _____ DATE _____

**EXECUTIVE**

SPECIAL ORDERS

SIGNED _____ DATE _____