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

Employer (Name & Address Including Zip) Clay County Board of Education 128 Richmond Road Manchester, KY 40962		Carrier/Administration Claim Number	Report Purpose Code
		Jurisdiction	Jurisdiction Claim Number
		Insured Report Number KY	
		Employer's Location Address (if different)	Location #
SIC Code	Employer FEIN		Phone #

Carrier/Claims Administrator

Kentucky Employers' Mutual Ins. Lexington Financial Center 250 W. Main Street, Suite 900 Lexington, KY 40507 Telephone: (859) 425-7800 Fax: (859) 425-7822		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

Name (Last, First, Middle)	Date of Birth	Social Security No.	Date Hired	State of Hire
Address (include 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	

Wage

Rate	Per ☐ Day ☐ Month ☐ Week ☐ 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, materials, or chemicals employee was using when accident or illness exposure occurred			
Specify 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 Returned 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 #)					
Date Admin/Carrier Notified	Date Prepared	Preparer's Name & Title	Phone Number		

FORM IA-1 **SEE BACK FOR IMPORTANT INFORMATION & SIGNATURE**

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