First Report of Injury or Illness (FROI)

EMPLOYER

☐ ☐ | Date prepared:

Employer's name: Potlatch School District #285 | Entity Type: ☐ Sole Proprietor ☐ Corporation ☐ LLC ☐ Partnership ■ Public ☐ Other

Address: 130 Sixth Street

City: Potlatch | State: ID | ZIP: 83855

Country: United States of America | Is injured worker a Corporate Officer, Partner, LLC member or Sole Proprietor? ☐ Yes ■ No

Employer's location address: 130 Sixth Street

City: Potlatch | State: ID | ZIP: 83855-8757 | If a Sole Proprietor or LLC, is the injured worker a household member? ☐ Yes ■ No

Country: United States of America | Policy #: 280310 | FEIN: 82-6000817

Phone: (208) 875-0327 | Email: | Organization code:

EMPLOYEE

Last name: | Suffix: | State where hired: Idaho

First name: | MI: | Occupation:

Address: | Employment status: Select one...

City: | State: | ZIP: | Social Security # or Federal ID#:

Country: | Sex: ☐ Female ☐ Male ☐ Unknown | Fed ID Type: Select one...

Phone: | Date of birth: | Date hired:

Class code wages reported: | W2 Employee: ☐ Yes ☐ No | Injury date:

Regular job/dept.: | Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown

WAGES

Wage rate: per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Other… explain:

Hours worked per week: ☐ Steady ☐ Variable | Days worked per week: ☐ Steady ☐ Variable

Full pay for the day of injury: ☐ Yes ☐ No If no, how many hours paid for the day of injury? | Did salary continue? ☐ Yes ☐ No

Comments on hours/days worked:

Avg. weekly value of board (lodging, meals, etc.) received in addition to wages: | Avg. weekly value of gratuities (tips, etc.) received:

ACCIDENT OR EXPOSURE

Place of accident/exposure (address): | City:

State: | ZIP: | County: | Country:

Did injury/illness occur on the employer's premises? ☐ Yes ☐ No | Time of injury: ☐ AM ☐ PM | Time employee began work: ☐ AM ☐ PM

Date last worked: | Date employer notified: | Injury reported to:

Date returned to work: | Date disability began: | If fatal, date of death:

Part(s) of body affected: | Side of body: | Body part injured before: ☐ Yes ☐ No

Injury type (strain, cut, etc):

Equipment, materials, or chemicals employee was using upon occurrence:

How injury or illness occurred:

Was accident caused by the failure of a machine or product? ☐ Yes ☐ No | Was safety equipment provided? ☐ Yes ☐ No Was it used? ☐ Yes ☐ No

Was the accident caused by any person or business other than the injured worker, co-worker, or the employer? ☐ Yes ☐ No Please identify: | Were other workers also injured? ☐ Yes ☐ No List other workers' names:

Witnesses to the accident: (name & phone):

MED

Medical Provider name & address: | ☐ No medical treatment ☐ Minor by employer ☐ Minor - clinic/hospital ☐ Emergency Care ☐ Hospitalized overnight

Anticipated major medical/time loss: ☐ Yes ☐ No

PREPARER

Name and title: | Role: ☐ Employer ☐ Injured worker ☐ Insurance Agent ☐ Attorney ☐ Medical Provider

Phone: | Email: | Prefer contact by: ☐ Phone ☐ Email

Do you question the claim? ☐ Yes ☐ No

Comments: