

CLAIM ADMIN	Claim Administrator Name:			Claim Representative Business Phone Number:		Insurer Name (if different than claim administrator):						
	Mailing Address, City, State, & Postal Code:			Claim Administrator Claim Number:		Insurer FEIN:						
				Claim Administrator FEIN:		Claim Type Code:						
EMPLOYER	Employer Name:			Employer FEIN:		Insured Report Number:		Employer Type Code: ___ Employer (E) ___ Lessor (L)				
	Physical Address, City, State, & Postal Code:			Mailing Address, City, State, & Postal Code:		Industry Code:		Employer UI Number:				
						Insured Location Number:						
	Nature of Business:			Employer Contact Name and Business Phone Number:								
POLICY	Insured Name (parent company if different than employer):		Insured FEIN:		Insured Postal Code:		Policy/Contract Number:		Coverage Effective Date:		Self Insurance License/ Certificate Number:	
							Coverage Expiration Date:					
EMPLOYEE	Employee Name (First, Middle, Last, & Suffix):			Date of Birth:		Gender: ___ Transgender (T) ___ Male (M) ___ Non-Binary (X) ___ Female (F) ___ Unknown (U)		Tax Filing Status (check one): ___ Single (A) ___ Married/Filing Joint (C) ___ Single/Head of Household (B) ___ Married/Filing Separate (D)				
	Mailing Address, City, State, & Postal Code:			Date of Hire:		State of Hire:		Educational Level (grade completed): _____ [GED = 12]		Marital Status: (check one) ___ Unmarried/Single/Divorced (U) ___ Married (M) ___ Separated (S)		
	Email:			Employment Status (check one): ___ Piece Worker ___ Volunteer ___ Seasonal ___ Apprenticeship/Full-Time ___ Apprenticeship/Part-Time ___ Regular Employee/Full-Time ___ Part-Time ___ Other		Employee ID Number (check one): ID # _____ ___ Social Security Number ___ Employment VISA Number ___ Passport Number ___ Green Card ___ Employee ID Assigned by Jurisdiction						
	Phone Number (include area code):											
	Occupation Description:											
	NCCI Classification Code:											
	Department Where Regularly Worked:							Employee's Authorization to Release the Following: Medical Records ___ yes ___ no Social Security Number ___ yes ___ no				
	WAGE	Average Wage \$ _____ (check one): ___ hourly ___ daily ___ semi-monthly ___ monthly ___ bi-weekly ___ annual ___ weekly			Salary Continued In Lieu of Compensation: ___ yes ___ no				Employee Number of Dependents: _____			
			Full Wages Paid for Date of Injury: ___ yes ___ no				Employee Number of Exemptions: _____ (check one) ___ Entitled ___ Withholding					
Number of Days Regularly Worked Per Week: _____			Discontinued Fringe Benefits: \$ _____									
ACCIDENT/INJURY	_____ Date of Injury _____ Date Employer Had Knowledge of the Injury _____ Date Claim Administrator Had Knowledge of the Injury _____ Initial Date Last Day Worked _____ Initial Return to Work Date (if applicable) _____ Employee Date of Death (if applicable)			Type of Injury / Illness Code: Describe the nature of the injury. (ex. amputation, burn, cut, fracture): Part of Body Affected Code: Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system): Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure): Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil): Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties: Witness Name & Business Phone Number:								
	_____ Time of Injury _____ Time Employee Began Work											
	Pre-Existing Disability Code: ___ Yes ___ No ___ Unknown											
	Accident Premises Code: ___ Employer (E) ___ Other (X) ___ Lessee (L) ___ Employee Residence (R)											
	Accident Site Organization Name:											
	Accident Site Street, City, State, & Postal Code:											
	Accident Location Narrative (if no street address):											
	Accident Site County/Parish:											
MEDICAL	Initial Treatment Code (check one): ___ no medical treatment (0) ___ minor/on-site treatment (1) ___ clinic/hospital visit (2) ___ emergency care (3) ___ hospitalization > 24 hours (4) ___ future medical treatment/lost time anticipated (5)			Initial Medical Provider Name:				Managed Care Organization Name or ID Number:				
				Initial Medical Provider Physical Address, City, State, & Postal Code:				ICD Primary Diagnostic Code (if known):				
Preparer's Name & Title:			Preparer's Company Name:				Phone Number:		Date:			

IOWA DIVISION OF WORKERS' COMPENSATION

www.iowaWorkComp.gov

FIRST REPORT OF INJURY OR ILLNESS REQUIREMENT

An employer or the employer's representative must file with the Iowa Division of Workers' Compensation (DWC) a First Report of Injury or Illness (FROI) in case of occupational:

- Fatality,
- Permanent disability, or
- Temporary disability lasting more than three days.

An employer or the employer's representative must file a FROI within four days of the event.

An employer or the employer's representative must file a FROI if the employee claims the disability is caused by work even if the employer or employer's representative disagrees.

For more information on these and other requirements, go to: www.iowaworkcomp.gov

RECORDS AND REPORTS

Every employer must keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day.

All books, records, and payrolls of an employer must be open for inspection by the Iowa Workers' Compensation Commissioner for purposes of administering the Iowa Workers' Compensation Act.

An employer must furnish to an employee upon request one statement of earnings, wages, or salary for the year preceding the injury. An employer may be subject to a civil penalty of \$1,000.00 per offense for failure to furnish such wage statement.

CIVIL PENALTY

The Commissioner may require an employer to appear and show why the employer should not be subject to a civil penalty of \$1,000.00 per occurrence for failure to comply with the reporting or inspection requirements. Upon hearing, if the facts indicate, the Commissioner may enter an order requiring payment of such penalty. Unless voluntarily paid, the Commissioner may petition the district court for entry of judgment on the order. The employer's insurance carrier shall be responsible in the same manner and to the same extent as the employer when a report of injury has been submitted to the employer's insurance carrier and not filed by it with the agency.

ADDITIONAL IOWA OSHA REPORTING REQUIREMENTS

Additional reporting and recordkeeping requirements may apply to the incident described in the FROI.

An employer must:

- Report a workplace fatality to Iowa OSHA within eight hours by calling 877-242-6742 or visiting www.iowaosha.gov for a form and instructions.
- Report a hospitalization, loss of an eye, or amputation within twenty-four hours by calling 877-242-6742 or visiting www.iowaosha.gov for a form and instructions.
- Complete an OSHA Form 301, or equivalent for recordable, work-related incidents within seven days and retain the completed form on site. The FROI is equivalent to the OSHA Form 301 if the case number from the OSHA 300 log is added. For more information, go to: www.osha.gov/recordkeeping
- Make an entry in your Log of Work-Related Injuries and Illnesses, OSHA Form 300, for recordable cases within seven days and retain the completed form on site. Some industries are exempt from this requirement. For more information, go to: www.osha.gov/recordkeeping

For more information on these and other OSHA requirements, go to: www.iowaosha.gov