Iowa Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS Jurisdiction Code _____ Jurisdiction Claim Number _____

CLAIM ADMIN

Claim Administrator Name: SEDGWICK CMS

Mailing Address, City, State, & Postal Code: P.O. BOX 14628, LEXINGTON, KY 40512 FAX (515) 327-4891

Claim Representative Business Phone Number: (515) 327-4888 (866) 342-3920

Claim Administrator Claim Number:

Claim Administrator FEIN: 362685608

Insurer Name (if different than claim administrator): STATE OF IOWA

Insurer FEIN: 420932069

Claim Type Code:

EMPLOYER

Employer Name: STATE OF IOWA

Physical Address, City, State, & Postal Code: 1305 E WALNUT, DES MOINES, IA 50319-0150

Nature of Business: GOVERNMENT

Employer FEIN: 420932069

Mailing Address, City, State, & Postal Code: SAME AS PHYSICAL ADDRESS

Insured Report Number:

Industry Code:

Insured Location Number:

Employer Type Code: X Employer (E) / __ Lessor (L)

Employer UI Number:

Employer Contact Name and Business Phone Number: RYAN IHRKE (515) 414-6212

POLICY

Insured Name (parent company if different than employer): N/A

Insured FEIN: N/A

Insured Postal Code: N/A

Policy/Contract Number: N/A

Coverage Effective Date: N/A

Coverage Expiration Date: N/A

Self Insurance License/ Certificate Number: N/A

EMPLOYEE

Employee Name (First, Middle, Last, & Suffix):

Mailing Address, City, State, & Postal Code:

Phone Number (include area code):

Occupation Description:

Manual Classification Code:

Department Where Regularly Worked:

Date of Birth:

Date of Hire:

Gender: __ Male (M) / __ Female (F)

Tax Filing Status (check one): ____ Single (A) / ____ Single/Head of Household (B) / ____ Married/Filing Joint (C) / ____ Married/Filing Separate(D)

Educational Level (grade completed): _____ [GED = 12]

Marital Status: (check one) ___ Unmarried (U) / ___ Married (M) / ___ Separated (S)

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

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

Number of Days Regularly Worked Per Week: _____

Salary Continued In Lieu of Compensation: ___ yes ___ no

Full Wages Paid for Date of Injury: ___ yes ___ no

Discontinued Fringe Benefits: $_____

Employee Number of Dependents: _____

Employee Number of Exemptions: _____ (check one) ___ Entitled / ___ Withholding

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)

_____ Time of Injury
_____ Time Employee Began Work

Pre-Existing Disability Code: ___ Yes / ___ No / ___ Unknown

Accident Premises Code: ___ Employer (E) / ___ Lessee (L) / ___ Other (X)

Accident Site Organization Name:

Accident Site Street, City, State, & Postal Code:

Accident Location Narrative (if no street address):

Accident Site County/Parish:

Describe the nature of the injury. (ex. amputation, burn, cut, fracture):

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:

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:

Initial Medical Provider Physical Address, City, State, & Postal Code:

Managed Care Organization Name or ID Number:

ICD Primary Diagnostic Code (if known):

Preparer's Name & Title:

Preparer's Company Name:

Phone Number:

Date:

First Report of Injury or Illness Requirement

A First Report of Injury or Illness (First Report) must be filed by an employer or the employer's insurance carrier in case of occupational
- fatality,
- permanent disability; or,
- temporary disability lasing more than three days.

A First Report must be electronically filed within four days of the incident. An employer or insurance carrier must file a First Report if the employee says the disability is caused by work even if the employer disagrees.

For more information on these and other requirements, please call 515-281-5387 or visit http://www.iowaworkforce.org/wc/.

The Iowa Workers' Compensation Act RECORDS AND REPORTS

Every employer shall keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day. An employer with notice or knowledge of an injury which temporarily disables an employee for more than three days or results in permanent total disability, permanent partial disability or death is required to electronically file a report with the Workers' Compensation Commissioner within four days from such event when such injury is alleged by the employee to have been sustained in the course of employment.

All books, records, and payrolls of an employer are required to be open for inspection by the Workers' Compensation Commissioner for purposes of administration of the Iowa Workers' Compensation Act.

The Workers' Compensation 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 them with the Workers' Compensation Commissioner.

The employer is required to furnish to an employee, on request, one statement of earnings, wages, or salary for the year preceding the injury. An employer may be subject to a civil penalty of $1000.00 per offense for refusal to furnish such wage statement.

Additional Iowa OSHA Reporting Requirements

Additional reporting and recordkeeping requirements may apply to the incident described on the First Report. An employer must:

- Report a workplace fatality to Iowa OSHA within 8 hours. You may report by calling 877-242-6742 or visit www.iowaosha.gov for a form and instructions.
- Report a hospitalization, the loss of any eye, or an amputation to Iowa OSHA within 24 hours. You may report by calling 877-242-6742 or visit 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 First Report is equivalent to the OSHA Form 301 if the case number from the OSHA 300 log is added. Visit www.osha.gov/recordkeeping for more information.
- 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. Visit www.osha.gov/recordkeeping for more information.

For more information on these and other OSHA requirements, please visit www.Iowaosha.gov or call 515-242-5870.

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