INDUSTRIAL COMMISSION OF ARIZONA

800 W WASHINGTON STREET
PHOENIX, ARIZONA 85007
(602) 542-4661

WORKER'S REPORT OF INJURY

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the Industrial Commission of Arizona claims and hearing process are available at the Industrial Commission offices and through the ICA web-site located at: www.azica.gov

ANSWER ALL QUESTIONS FULLY

1. **NAME OF INJURED WORKER:** LAST FIRST M.I.
   SOCIAL SECURITY # *: **BIRTH DATE:** **PHONE #:**
2. **ADDRESS:** CITY STATE ZIP CODE
3. **MARITAL STATUS:** SINGLE MARRIED DIVORCED **DEPENDENTS AT TIME OF INJURY:** YES NO
4. **EMPLOYER:** **SUPERVISOR:**
5. **PHONE #:**
   EMPLOYER ADDRESS: CITY STATE ZIP CODE
6. **DATE HIRED:** **WHERE HIRED:** **OCCUPATION:**
7. **HOURS WORKED PER DAY:** **PER WEEK:** **HOURLY WAGE:**
8. **DID YOU RECEIVE FOOD OR LODGING IN ADDITION TO WAGE?** YES NO
9. **DATE OF INJURY (MO/DAY/YEAR):** **TIME OF INJURY:** AM PM
10. **ADDRESS OR LOCATION OF ACCIDENT:**
11. **DID YOU STOP WORK IMMEDIATELY?** **WHEN DID YOU STOP?**
12. **WHEN DID YOU REPORT THE INJURY?** **TO WHOM?** **TITLE:**
13. **WHEN DID YOU RETURN TO WORK?** **REGULAR WORK** **OTHER WORK**
14. **NAMES OF PERSONS WHO SAW THE ACCIDENT.**
    1. **NAME:** **ADDRESS:** **PHONE #:**
    2. **NAME:** **ADDRESS:** **PHONE #:**
15. **WAS ACCIDENT CAUSED BY ANOTHER PERSON?** **IF SO, BY WHOM?**
16. **NAME OF MACHINE OR TOOL WHICH MAY HAVE CAUSED THE ACCIDENT:**
17. **STATE HOW ACCIDENT HAPPENED:**
18. **BODY PART INJURED:** **DESCRIBE THE INJURY (CUT, BRUISE, ETC.):**
19. **WHERE WERE YOU FIRST TREATED:** **NAME:** **ADDRESS:**
20. **WHO TREATED YOU FOR THIS INJURY:** **NAME:** **ADDRESS:**
21. **OTHER THAN THIS INJURY, HAVE YOU LOST TIME FROM WORK DUE TO AN ACCIDENT IN THE PAST 12 MONTHS?** YES NO
    NAME OF STATE WHERE ACCIDENT HAPPENED: **WORK INJURY:** YES NO
22. **OTHER THAN THIS INJURY, HAVE YOU EVER RECEIVED ANY PERMANENT DISABLING INJURY?** YES NO
    DATE OF INJURY: **WORK INJURY:** YES NO
    NAME OF STATE WHERE ACCIDENT HAPPENED:
23. **OTHER THAN THIS INJURY, ARE YOU RECEIVING COMPENSATION FOR ANY DISABLING CONDITIONS?** YES NO
    IF SO, FROM WHOM? **AMOUNT?** **WHY?**

I make application for all benefits to which I may be entitled under the law. I certify, with full knowledge that it is a crime to make willful, false statements to obtain compensation and that all of my statements on this form are true, accurate and complete.

Signature of injured worker or injured worker's authorized representative is REQUIRED. **Date**

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

Submitter Email Address

Employer Email Address: **Worker Email Address:**

THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT CLAIMS AT (602 542-4661).

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND SUBMIT THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment.

ARIZONA REVISED STATUTES 23-908 & 23-1061

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

FOR CARRIER USE ONLY

FOR OSHA PURPOSES ONLY

OSHA Case #: ____________

RECORDABLE INJURY ____________

NON-RECORDABLE INJURY ____________

EMPLOYEE

1. LAST NAME | FIRST | M.I.
2. SOCIAL SECURITY NUMBER *
3. BIRTH DATE
4. HOME ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE
5. TELEPHONE
6. SEX: MALE | FEMALE
7. MARITAL STATUS: SINGLE | MARRIED | DIVORCED | WIDOWED

EMPLOYER

8. EMPLOYER'S NAME
9. POLICY NUMBER
10. NATURE OF BUSINESS (MANUFACTURING, ETC.)
11. OFFICE ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE
12. TELEPHONE

ACCIDENT

13. DATE OF INJURY OR ILLNESS
14. TIME OF EVENT
15. TIME EMPLOYEE BEGAN WORK
16. DATE EMPLOYER NOTIFIED OF INJURY
17. LAST DAY OF WORK AFTER INJURY
18. DATE OF RETURN TO WORK
19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED
20. CLASS CODE ON PAYROLL REPORT
21. EMPLOYEE'S ASSIGNED DEPARTMENT
22. DEPARTMENT NUMBER
23. DID INJURY OCCUR ON EMPLOYER PREMISES? YES | NO
24. ADDRESS OR LOCATION OF ACCIDENT | CITY | COUNTY | STATE | ZIP CODE
25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
26. PART OF BODY INJURED
27. FATAL: YES | NO
28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH
29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? YES | NO

NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL | ADDRESS | CITY | STATE | ZIP CODE

30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? YES | NO

IF HOSPITALIZED, HOSPITAL NAME | ADDRESS | CITY | STATE | ZIP CODE

31. IS VALIDITY OF CLAIM DOUBTED: YES | NO

31.a IF YES, STATE REASON

CAUSE OF ACCIDENT

32. **WHAT HAPPENED?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
33. **WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*
34. **WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? YES | NO
37. HOURS PER DAY EMPLOYEE WORKED: FROM | THRU
38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? YES | NO
39. NUMBER OF DAYS PER WEEK USUALLY WORKED: EMPLOYEE | COMPANY

IMPORTANT — IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

40. DATE OF LAST HIRE
41. WAS WORKER PAID FOR DAY OF INJURY? YES | NO | IF YES, $
42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? YES | NO
43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR
44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE: HOUR | DAY | WEEK | MONTH — $ PER
45. IS EMPLOYEE FURNISHED: LODGING | BOARD | BOTH — VALUE $
46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)
47. DOES EMPLOYEE CLAIM DEPENDENTS? YES | NO

IMPORTANT — IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55

48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR
49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK
50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEEDING INJURY: FROM | THRU | $
51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY: FROM | THRU | $
52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY
53. WAGE BEFORE INCREASE $
54. WAGE AFTER INCREASE $
55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $

AUTHORIZED SIGNATURE

DATE | AUTHORIZED SIGNATURE | TITLE

SUBMITTER EMAIL ADDRESS

NOTE TO EMPLOYER:

1. Submit one copy to the Industrial Commission within 10 days.
2. Submit one copy to your insurance carrier within 10 days.
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

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THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

INDUSTRIAL COMMISSION OF ARIZONA
800 W WASHINGTON STREET
PHOENIX, ARIZONA 85007
(602) 542-4661
WORKER'S & PHYSICIAN'S REPORT OF INJURY

IMMEDIATELY UPON COMPLETION PLEASE MAIL COPIES AS SHOWN BELOW

INJURED WORKER'S RIGHT TO CHOOSE DOCTOR

An employer who is not self-insured can direct you to a doctor of their choice for ONE visit. After the **ONE** visit, you may report to a doctor of your choice. **REMEMBER:** If you make a **SECOND** visit to the employer's doctor, you have established that doctor as your treating doctor. If your employer is self-insured, you may not be allowed to change doctors. **SEE INFORMATION SHEET ATTACHED TO THIS FORM FOR FURTHER INSTRUCTIONS.**

WORKER'S REPORT

ICA USE ONLY
INJURY CODE: ______________

NAME OF INJURED WORKER
LAST NAME FIRST M.I.
SOCIAL SECURITY NO.
PHONE NO.

1.

2. ADDRESS CITY STATE ZIP

3. DATE OF BIRTH 4. SEX: MALE FEMALE

5. SINGLE WIDOWED DIVORCED MARRIED IF SO, IS SPOUSE EMPLOYED YES NO

6. OCCUPATION WHEN INJURED DATE OF INJURY TIME OF INJURY

7. ÒT ÚŠUŸÒÜ SUPERVISOR PHONE NO.

8. OFFICE ADDRESS CITY STATE ZIP

9. EMPLOYER'S INSURANCE CARRIER POLICY NO.

10. MAILING ADDRESS

11. DESCRIBE **WHERE** AND **HOW** ACCIDENT OR CAUSE OF DISABILITY OCCURRED (INCLUDING LOCATION AND/OR DEPARTMENT)

BY THIS INSTRUMENT I MAKE APPLICATION FOR ALL BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE LAW AND I DO HEREBY CERTIFY, WITH FULL KNOWLEDGE THAT IT IS A CRIME TO MAKE WILLFUL, FALSE STATEMENTS TO OBTAIN COMPENSATION, THAT ALL OF MY STATEMENTS ON THIS FORM ARE TRUE, ACCURATE AND COMPLETE. I UNDERSTAND I MUST FOLLOW THE INSTRUCTIONS OF MY DOCTOR AND MUST HAVE WRITTEN APPROVAL FROM THE INDUSTRIAL COMMISSION TO LEAVE THE STATE OF ARIZONA OR MY LOCALITY FOR MORE THAN 14 DAYS, FAILURE TO DO SO MAY CAUSE FORFEITURE OF COMPENSATION BENEFITS.

WORKER EMAIL ADDRESS DATE OF SIGNING AT CITY STATE
EMPLOYER EMAIL ADDRESS

IMPORTANT: INJURED WORKER'S SIGNATURE REQUIRED HERE **X** ______________________________

PHYSICIAN'S INITIAL REPORT

12. DATE FIRST TREATMENT HOUR 13. LOCATION: HOSPITAL OFFICE OTHER

14. DATE WORKING DISABILITY BEGAN 15. WHO ENGAGED YOUR SERVICES? PATIENT EMPLOYER OTHER

16. WAS PATIENT TREATED BY ANYONE ELSE? YES NO IF YES, BY WHOM?

17. COMPLAINTS AND PHYSICAL FINDINGS IN DETAIL:

18. ICD- CODE : DIAGNOSIS:

19. DESCRIBE ANY PRE-EXISTING IMPAIRMENT OR DISEASE AFFECTING PRESENT CONDITION

20. PATIENT IS RIGHT LEFT HANDED

21. DESCRIBE TREATMENT GIVEN BY YOU:

22. WERE X-RAYS TAKEN? YES NO IF YES, BY WHOM? WHEN

23. WAS LABORATORY WORK DONE? YES NO IF YES, BY WHOM WHEN

24. X-RAY DIAGNOSIS (ATTACH ROENTGENOLOGICAL REPORT FORM)

25. WAS PATIENT HOSPITALIZED? YES NO IF YES, WHERE

26. DATE OF ADMISSION TO HOSPITAL 27. DATE OF DISCHARGE

28. IS FURTHER TREATMENT NEEDED? YES NO IF YES, FOR HOW LONG

29. IS PATIENT, AS A RESULT OF CONDITIONS DUE TO THIS ACCIDENT: (A) SUBJECT TO SUSTAIN A PERMANENT DEFECT OF IMPAIRMENT? YES NO
(B) ABLE TO DO THE SAME TYPE OF WORK HE PERFORMED AT TIME OF INJURY? YES NO IF YES, DATE ABLE IF NOT, ANTICIPATED DATE
(C) ABLE TO DO A LIGHTER OR DIFFERENT TYPE OF WORK THAN PERFORMED AT TIME OF INJURY? YES NO IF YES, DATE ABLE
IF NOT, ANTICIPATED DATE ABLE

30. REMARKS:

NAME OF PHYSICIAN BILLING CODE NO.
ADDRESS ZIP PHONE
IRS. NO. PROFESSIONAL CORP? YES NO
DATE OF THIS REPORT PHYSICIAN'S SIGNATURE REQUIRED HERE **X** ______________________________

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