# WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

| EMPLOYER (NAME & ADDRESS INCL ZIP) | CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG CASE # | REPORT PURPOSE CODE |
|---|---|---|---|
| | JURISDICTION | JURISDICTION CLAIM NUMBER | |
| | INSURED REPORT NUMBER | | |
| | EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | | LOCATION # |
| INDUSTRY CODE / EMPLOYER FEIN | | | PHONE # |

## CARRIER/CLAIMS ADMINISTRATOR

| CARRIER (NAME, ADDRESS, & PHONE #) | POLICY PERIOD TO<br>CHECK IF APPROPRIATE<br>☐ SELF INSURANCE | CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) |
|---|---|---|
| CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN |

## EMPLOYEE/WAGE

| NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE |
|---|---|---|---|---|
| ADDRESS (INCL ZIP) | SEX<br>M MALE<br>F FEMALE<br>U UNKNOWN | MARITAL STATUS<br>U UNMARRIED SINGLE/DIVORCED<br>M MARRIED<br>S SEPARATED<br>K UNKNOWN | OCCUPATION/JOB TITLE<br>EMPLOYMENT STATUS | |
| PHONE | # OF DEPENDENTS | | NCCI CLASS CODE | |

| RATE PER: | ☐ DAY ☐ WEEK | ☐ MONTH ☐ OTHER: | DAYS WORKED/WEEK | FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE? | ☐ YES ☐ YES | ☐ NO ☐ NO |
|---|---|---|---|---|---|---|

## OCCURRENCE/TREATMENT

| TIME EMPLOYEE BEGAN WORK | ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE<br>( ) CANNOT BE DETERMINED | ☐ 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 |
|---|---|
| SPECIFIC 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 RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?<br>WERE THEY USED? | ☐ YES ☐ NO<br>☐ YES ☐ NO |
|---|---|---|---|

| PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS) | HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS) | INITIAL TREATMENT |
|---|---|---|
| | | 0 NO MEDICAL TREATMENT<br>1 MINOR: BY EMPLOYER<br>2 MINOR CLINIC/HOSP<br>3 EMERGENCY CARE<br>4 HOSPITALIZED > 24 HOURS<br>5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED |

## OTHER

WITNESSES (NAME & PHONE #)

| DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER |
|---|---|---|---|

AWCC Form 1

**(Employer's First Report of Injury or Illness)**

**Ark. Code Ann. § 11-9-529** allows employers 10 days to report injuries. Those involving either more than 7 days of lost time or indemnity payments require **Form 1**. Also, a Form 1 is required for all controversions including a medical-only case. Self-insured employers file **Form 1** with the AWCC; other employers send it to their insurance representatives.

Employers do **NOT** fill in the shaded areas.

On **Form 1**, employers/carriers must:

1. In the **Occurrence Section** list the date the employer first knew of the injury. The 10 days to report begin either on the date of disability **or** the date the employer was notified, whichever date is later.

2. Give the name of the carrier. An insurance agency or third party administrator should be listed in the **Preparer's Section**. A carrier can pre-print its name and address in the **Carrier Section** to help clients properly report.

3. Specify the carrier Federal Employer Identification Number (FEIN) in the **Carrier Section**.

4. Type or print in ink. An illegible, incomplete **Form 1** will be returned.

Neglect of **Form 1**: Late employee benefits, exposing employers to fines.

Lack of **Form 1**: Delays in insurance investigation.

**General inquiries on Form 1 can be answered by the AWCC Support Services Division. Questions on a specific Form 1 may be directed to the Research and Statistics Section, which processes the accident reports. (1-800-622-4472 or 501-682-3930).**

**Ark. Code Ann. §11-9-106(a):** "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

(Revised 1-1-2001)