

EMPLOYER'S REPORT OF INDUSTRIAL INJURY		INDUSTRIAL COMMISSION OF ARIZONA P.O. BOX 19070 PHOENIX, ARIZONA 85005-9070		FOR CARRIER USE ONLY		
COMPLETE AND MAIL 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		MAIL TO: (CARRIER NAME & ADDRESS)		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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		7. MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 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 <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		15. TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
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? <input type="checkbox"/> YES <input type="checkbox"/> 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." <i>Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."</i>						
26. PART OF BODY INJURED			27. FATAL <input type="checkbox"/> YES <input type="checkbox"/> NO		28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH	
29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL			ADDRESS (STREET, CITY, STATE & ZIP CODE)	
30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF HOSPITALIZED, HOSPITAL NAME			ADDRESS (STREET, CITY, STATE & ZIP CODE)	
31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON						
CAUSE OF ACCIDENT	32. WHAT HAPPENED? Tell us how the injury occurred. <i>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."</i>					
33. WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE? <i>Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.</i>						
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. <i>Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."</i>						
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? <input type="checkbox"/> YES <input type="checkbox"/> NO		37. HOURS PER DAY EMPLOYEE WORKED		38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, \$	
43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR		44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE HOUR DAY WEEK MONTH \$ per <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		45. IS EMPLOYEE FURNISHED <input type="checkbox"/> LODGING <input type="checkbox"/> BOARD <input type="checkbox"/> BOTH \$		
46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)					47. DOES EMPLOYEE CLAIM DEPENDENTS? <input type="checkbox"/> YES <input type="checkbox"/> 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?		49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK	
50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEDING 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

NOTE TO EMPLOYER:

1. Mail one copy to the Industrial Commission within 10 days.
2. Mail 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.

* 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.

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

Form ICA 04-0101 (Rev. 7/01)

WC 8418e (7-01) UNIFORM INFORMATION SERVICES, INC.