EMPLOYER'S REPORT OF INDUSTRIAL INJURY

C D

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

FOR	CARRIER	USE	ONLY

	SUBMIT THIS REP ICE OF ACCIDENT									_	FOR (OSHA PURP	OSES O	<u>NLY</u>	
	TED WITHIN 24 HO		IES							OSHA Case	#:				
mplover must, on this	s form, notify his insur	ance carrier o	of every							RECORDAB	I F INJU	RY			
jury or disease suffe	red by an employee, fa	atal or otherw	ise,												
	se out of or in the cou D STATUTES 23-9									NON-RECOR	KUABLE	INJURY			
EMPLOYEE	1. LAST NAME			FIRST			M.I.		2. SOCIA	L SECURITY NUMBE	R *		3. BIRTH	I DATE	
4. HOME ADDRESS (N	UMBER & STREET)		CITY						STATE	ZIP CODE		5. TELEPHON	IE		
6. SEX	LE FEMALE	7. MAR	RITAL STATUS:	S	SINGLE	MARRIEI	D	DI\	/ORCED	WIDOWE	D				
EMPLOYER	8. EMPLOYER'S NAMI	E				9	9. POLICY	NUMBI	ER		10. N	NATURE OF BUS	INESS (MAN	IUFACTURING	, ETC.)
11. OFFICE ADDRESS	(NUMBER & STREET)		CITY			I			STATE	ZIP CODE	1	12. TELEPHO	NE		
ACCIDENT	13. DATE OF INJURY OR ILLNESS 14. TIME OF EVENT			/ENT		15. TIME EMPLOYEE BEGAN WORK				16. DATE EMPLOYER NOTIFIED OF INJURY					
17. LAST DAY OF WO	RK AFTER INJURY	18. DA	TE OF RETURN TO	WORK	1	19. EMPLOY	YEE'S OCC	CUPATI	ON (JOB T	ITLE) WHEN INJURE	D	1			
20. CLASS CODE ON I	20. CLASS CODE ON PAYROLL REPORT 21. EMPLOYEE'S			S ASSIGNED DEPARTMENT 22. DEPARTMENT NUMBER					23. DID INJURY OCCUR ON EMPLOYER PREMISES?						
24. ADDRESS OR LOC	ATION OF ACCIDENT				CITY					YES		NO STA	TE	ZIP CODE	
24. ADDRESS OR LOC	ATION OF ACCIDENT				CITY					COUNTY		514	.16	ZIP CODE	
25. WHAT WAS THE II	NJURY OR ILLNESS? Te	Il us the part of the	he body that was af	ected and	I how it was affected	ed; be more :	specific tha	an "hurt,	," "pain," or	sore." Examples: "str	ained bad	k"; "chemical burn	n, hand"; "car	pal tunnel synd	rome."
26. PART OF BODY IN	JURED			27. F	FATAL	YES		NO	28. IF T	HE EMPLOYEE DIED	, WHEN	DID THE DEATH	OCCUR? D	ATE OF DEATI	Н
29. WAS EMPLOYEE 1 ROOM?	REATED IN AN EMERGE		ME OF PHYSICIAN	OR OTHE	R HEALTH CARE	PROFESSI	ONAL	Al	DDRESS		CITY			STATE Z	IP CODE
30. WAS EMPLOYEE H AN IN-PATIENT?	YES OSPITALIZED OVERNIG		OSPITALIZED, HO	SPITAL N	AME			A	DDRESS		CITY			STATE Z	IP CODE
31. IS VALIDITY OF CL	YES AIM DOUBTED	NO 31.a	a IF YES, STATE F	EASON											
	YES	NO													
CAUSE OF	 WHAT HAPPENED developed soreness in v 		he injury occurred.	Examples	: "When ladder sli	pped on wet	floor, work	er fell 2	20 feet"; "W	orker was sprayed wit	h chlorine	when gasket bro	ke during rep	lacement"; "W	orker
ACCIDENT	•														
33. WHAT OBJECT OF	R SUBSTANCE DIRECTL	Y HARMED THE	E EMPLOYEE? Ex	amples: "(concrete floor"; "c	hlorine"; "rad	dial arm sa	w." If ti	his question	does not apply to the	incident,	leave it blank.			
	OYEE DOING JUST BEFO lying chlorine from hand sp			Describe	e the activity, as we	ell as the too	ols, equipmo	ent, or r	material the	employee was using.	Be speci	fic. Examples: "o	climbing a lac	dder while carryi	ing
35. IF ANOTHER PERS	SON NOT IN COMPANY E	EMPLOY CAUSE	ED ACCIDENT, GIV	E NAME A	AND ADDRESS										
EMPLOYEE'S	36. WAS WORKER IN WHEN INJURED?	YOUR EMPLOY	Y 37. HOURS	PER DAY	EMPLOYEE WO	RKED			38. WAS WHEN IN	EMPLOYEE ON OVE JURED?	RTIME	39. NUME USUALLY		S PER WEEK	
WAGE DATA	YES	NO	FROM		THRU					YES	NO	EMPLOYE		COMPANY	
IMPORTANT	IF WORK LOSS IS EXF CALENDAR DAYS, CO	PECTED TO EXC MPLETE ITEMS	EXCEED SEVEN 40. DATE OF LAST HIRE MS 40 THRU 47				41. WAS WORKER PAID FOR DAY OF INJURY? YES NO IF YES, \$			AY OF INJURY?	42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? YES NO				
					AS APPLICABLE WEEK MONTH	1						V.	ALUE	NO	
	ARNINGS OF EMPLOYE				ING INJURY		LODGING	3	BOA 47	RD BOTH '. DOES EMPLOYEE		EPENDENTS?	YE	S NO)
(EXAMPLE: IF INJURE	D APRIL 8, GIVE EARNIN	IGS FROM MAR	CH 9 THRU APRIL	7)					"	. 5020 2 20122	02	2. 2.1.52.11.0.			
IMPORTANT	IF EMPLOYEE IS PAID OR MONTHLY SALARY				IF EMPLOYEE EA MENT?	RNS EXTRA	A PAY FOR	OVER	TIME, WH	AT IS BASIS OF PER HOUR		MBER OF HOUR AL PER WEEK	S OVERTIM	E CONSIDERE	.D
50. GROSS WAGES O	F EMPLOYEE DURING 1:	2 MONTHS PRE	CEEDING INJURY	1			F EMPLOY			SS THAN 12 MONTHS	S, SHOW		FROM DAT	E OF HIRE THI	ROUGH
FROM 52. DATE OF LAST WA	THRU AGE INCREASE IF	53. WAGE B	EFORE INCREASE	1	54. WAGE AFTI	FROI ER INCREAS		55. (GROSS EA	THRU RNINGS FROM DATE	OF INC			INJURY	
	NTHS PRIOR TO INJURY			\$ \$											
AUTHORIZED	D DATE AUTHOR			RIZED SIGNATURE						TITLE					
SIGNATURE															

SUBMITTER EMAIL ADDRESS

NOTE TO EMPLOYER:

- Submit one copy to the Industrial Commission within 10 days.
- Submit one copy to your insurance carrier within 10 days.

 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.