EMPLOYER'S REPORT OF INDUSTRIAL INJURY

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

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An employer must on this form notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, arising out of and in the course of employment.
ARIZONA REVISED STATUTES 23-908 & 23-1061

MAIL *ORIGINAL* TO:
INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

MAIL *COPY* TO:
SCF of Arizona
P.O. BOX 33069
PHOENIX, ARIZONA 85067-3069
1-800-231-1363
FAX 1-800-356-4867
WWW.SCFAZ.COM

FOR CARRIER USE ONLY

DOC TYPE: **IR101**

FOR OSHA PURPOSES ONLY

OSHA CASE NO.

RECORDABLE INJURY

NON-RECORDABLE INJURY

EMPLOYER'S NAME

OFFICE ADDRESS

EMPLOYEE 1. LAST NAME FIRST NAME M.I.

2. SOCIAL SECURITY NUMBER 3. BIRTHDATE

4. HOME ADDRESS (NUMBER & STREET/MAILING) APT. #

CITY STATE ZIP CODE

5. (AREA CODE) TELEPHONE DATE OF HIRE

6 SEX. ☐ M ☐ F 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 ☐ A.M. ☐ P.M. 15. TIME EMPLOYEE BEGAN WORK ☐ A.M. ☐ P.M. 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".

26. PART OF BODY INJURED Side Injured RT ☐ LT ☐ 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 (STREET, CITY, STATE & ZIP CODE)

30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ YES ☐ 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. *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 A.M. P.M. THRU A.M. P.M. 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 $ PER HOUR ☐ DAY ☐ WEEK ☐ MONTH ☐ 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 THROUGH 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.