

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP) Grant Parish School Board PO Box 208 / 512 Main Street Colfax, LA 71417 Phone # 318-627-3274		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE		
		JURISDICTION Louisiana		JURISDICTION CLAIM NUMBER		
		INSURED REPORT NUMBER				
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)			LOCATION #	
INDUSTRY CODE	EMPLOYER FEIN		PHONE # 318-627-3274			
CARRIER/CLAIMS ADMINISTRATOR						
CARRIER (NAME, ADDRESS, & PHONE #) Accident Fund National Insurance Co PO Box 40790 Lansing, MI 48901-7990 Phone # 1-866-206-5851		POLICY PERIOD 5/13/18 TO		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) Accident Fund National Ins Co AccidentFund.com ClaimsExpress@AccidentFund.com Fax # 1-866-814-5595		
		CHECK IF APPROPRIATE SELF INSURANCE <input type="checkbox"/>				
CARRIER FEIN	POLICY/SELF-INSURED NUMBER WCV 6165527		ADMINISTRATOR FEIN			
AGENT NAME & CODE NUMBER						
* EMPLOYEE/WAGE						
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE	
ADDRESS (INCL ZIP)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		MARITAL STATUS <input checked="" type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		
		# OF DEPENDENTS		OCCUPATION/JOB TITLE		
PHONE				EMPLOYMENT STATUS		
				NCCT CLASS CODE		
RATE PER:	<input type="checkbox"/> DAY WEEK	<input type="checkbox"/> MONTH OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
OCCURRENCE/TREATMENT						
TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE () CANNOT BE DETERMINED	<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	
CONTACT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> 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? WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)		INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC/HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HOURS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED		
OTHER						
WITNESSES (NAME & PHONE #)						
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER	

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IAIABC 2002

EMPLOYEE SIGNATURE