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.

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

MAIL TO: (CARRIER NAME & ADDRESS)

FOR	CARRIER	USE	ONLY

OSHA Case #:

FOR OSHA PURPOSES ONLY

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 our of or in the course of employment. ARIZONA REVISED STATUTES 23-908 & 23-1061							NON-RECORDABLE INJURY				
EMPLOYEE	1. LAST NAME		FIR	ST	M.I.	2. SO	CIAL SECURITY NUMBE	ER *		3. BIRTH DATE	
4. HOME ADDRESS (N	JUMBER & STREET)		С	ITY	STATE		ZIP CODE		5. TELEPHONI		
6. SEX MALE FEMALE 7. MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED											
EMPLOYER	8. EMPLOYER'S NAMI				9. POLICY	NUMBER		10. NA	TURE OF BUSIN	NESS (MANUFACTURIN	NG, ETC.)
11. OFFICE ADDRESS	(NUMBER & STREET)		С	ITY	STATE		ZIP CODE		12. TELEPHON	IE	
ACCIDENT	13. DATE OF INJURY	OR ILLNESS	14. TIME OF E	EVENT A.M.	P.M.	i. TIME EMPL	OYEE BEGAN WORK A.M.	P.M.	16. DATE EMPI	OYER NOTIFIED OF I	NJURY
17. LAST DAY OF WOR	RK AFTER INJURY	18. DA	TE OF RETURN TO WORK	(19. E	MPLOYEE'S OCC	UPATION (JOI	B TITLE) WHEN INJURE	D			
20. CLASS CODE ON F	PAYROLL REPORT	21. EM	PLOYEE'S ASSIGNED DE	PARTMENT 22. D	EPARTMENT NUM	MBER	23. DID INJURY	OCCUR ON NO		REMISES?	
24. ADDRESS OR LOC	CATION OF ACCIDENT			CITY	(С	OUNTY	S	TATE	ZIP COI	DE
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, hand"; "carpal tunnel syndrome."											
26. PART OF BODY IN	JURED		27	. FATAL Y	ES	NO 28.	IF THE EMPLOYEE DIED	D, WHEN DID	THE DEATH C	CCUR? DATE OF DEA	ATH
29. WAS EMPLOYEE T ROOM?	TREATED IN AN EMPERG	ENCY NAME	ME OF PHYSICIAN OR OTI	HER HEALTH CARE PRO	FESSIONAL		ADDRESS (STRE	EET, CITY, ST	TATE & ZIP COI	DE)	
30. WAS EMPLOYEE H AN IN-PATIENT?	HOSPITALIZED OVERNIGH	IT AS IF H	IOSPITALIZED, HOSPITAL	NAME			ADDRESS (STRE	EET, CITY, ST	TATE & ZIP COI	DE)	
31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON											
CAUSE OF ACCIDENT	32. WHAT HAPPENED developed soreness in v		ne injury occurred. Exampl	es: "When ladder slipped	on wet floor, work	er fell 20 feet";	"Worker was sprayed w	rith chlorine w	hen gasket brok	e during replacement";	"Worker
	1										
33. WHAT OBJECT OF	R SUBSTANCE DIRECTLY	/ HARMED THE	EMPLOYEE? Examples:	"concrete floor"; "chlorin	e"; "radial arm sav	ı." If this ques	tion does not apply to the	e incident, lea	ave it blank.		
34. WHAT WAS EMPL roofing materials"; "spra	OYEE DOING JUST BEFO aying chlorine from hand sp	ORE THE INCIDI orayer"; "daily co	ENT OCCURRED? Describ mputer key-entry."	be the activity, as well as	the tools, equipmen	nt, or material t	the employee was using.	Be specific.	Examples: "cli	mbing a ladder while ca	arrying
35. IF ANOTHER PERS	SON NOT IN COMPANY E	MPLOY CAUSED	ACCIDENT, GIVE NAME	AND ADDRESS							
EMPLOYEE'S WAGE DATA	36. WAS WORKER IN WHEN INJURED?	YOUR EMPLOY	37. HOURS PER DA	AY EMPLOYEE WORKED)		AS EMPLOYEE ON OVE NINJURED?	ERTIME NO	39. NUMBE USUALLY V	ER OF DAYS PER WEE VORKED	EK
IMPORTANT	FROM A.M. P.M. THRU IF WORK LOSS IS EXPECTED TO EXCEED SEVEN 40. DATE OF LAST HIRE				A.M. P.M. 41. WAS WORKER PAID FOR DAY OF INJURY?			42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT?			
43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR HOUR DAY WEEK MONTH					45. IS EMPLOYEE FURNISHED VALUE						
	ARNINGS OF EMPLOYEE D APRIL 8, GIVE EARNING		PER D DALENDAR DAYS PRECEED (CH 9 THRU APRIL 7)	DING INJURY	LODGING		30ARD BOTH 47. DOES EMPLOYEE		\$ PENDENTS?	☐ YES ☐	NO
IMPORTANT	IF EMPLOYEE IS PAID OR MONTHLY SALARY			. IF EMPLOYEE EARNS YMENT?	EXTRA PAY FOR	OVERTIME, W	/HAT IS BASIS OF PER HOUR		BER OF HOURS PER WEEK	OVERTIME CONSIDE	RED
50. GROSS WAGES O	F EMPLOYEE DURING 12	MONTHS PREG			51. IF EMPLOY DAY PRIOR TO		LESS THAN 12 MONTHS	S, SHOW GR			HROUGH
FROM 52. DATE OF LAST WA		53. WAGE B	\$ EFORE INCREASE	54. WAGE AFTER IN	FROM ICREASE	55. GROSS	THRU EARNINGS FROM DATE	E OF INCREA	ASE THRU DAY		
WITHIN 12 MONTHS PE	RIOR TO INJURY DATE	\$	AUTHORIZED SIGNATU	\$		\$		TITLE			
SIGNATURE				· · =							

NOTE TO EMPLOYER:

- Mail one copy to the Industrial Commission within 10 days.

Mail 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.