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:
AUTO-OWNERS INSURANCE CO.
P.O. BOX 10098
MESA, AZ 85216

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 ☐ MALE ☐ FEMALE
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, hand"; "carpal tunnel syndrome."
26. PART OF BODY INJURED
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 VALUE ☐ LODGING ☐ BOARD ☐ 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? ☐ 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 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.

EMPLOYEE'S NOTICE TO REJECT TERMS OF THE ARIZONA WORKMEN'S COMPENSATION LAW

POLICY NO. _____ DATE _____

To _____
(Full Name of Employer)

_____
(Address of Employer in Full)

YOU ARE HEREBY NOTIFIED THAT THE UNDERSIGNED ELECTS TO REJECT THE TERMS, CONDITIONS AND PROVISIONS OF THE LAW FOR THE PAYMENT OF COMPENSATION, AS PROVIDED BY THE COMPULSORY COMPENSATION LAW OF THE STATE OF ARIZONA, AND ACTS AMENDATORY THERETO.

_____ _____

_____ _____

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the workmen's compensation insurance carrier.

Form No. ICA 04-0113-78

EMPLOYEE'S NOTICE TO REVOKE REJECTION OF THE TERMS OF THE WORKMEN'S COMPENSATION LAW

POLICY NO. _____ DATE _____

To _____
(Full Name of Employer)

_____
(Address of Employer in Full)

I HEREBY REVOKE THE NOTICE OF REJECTION OF THE TERMS OF THE WORKMEN'S COMPENSATION LAW SIGNED BY ME ON _____
(Address of Employer in Full)

_____ _____
(Employee Print Name Here) (Social Security Number of Employee)

_____ _____
(Address of Employee) (Signature of Employee)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the workmen's compensation insurance carrier.