

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP) City of Frankfort P.O. Box 697 Frankfort, KY 40602		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
		JURISDICTION		JURISDICTION CLAIM NUMBER
		INSURED REPORT NUMBER		
INDUSTRY CODE		EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
			LOCATION #	PHONE #
CARRIER/CLAIMS ADMINISTRATOR				
CARRIER (NAME, ADDRESS, & PHONE #) Health Smart Attn: Sue Martin 220 Lexington Green Cr. 214 Lexington, KY 40503		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) Health Smart Attn: Sue Martin 220 Lexington Green Cr. 214 Lexington, KY 40503	
CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE				
CARRIER FEIN	POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN	
AGENT NAME & CODE NUMBER				
EMPLOYEE/WAGE				
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED
ADDRESS (INCL ZIP)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	OCCUPATION/JOB TITLE
PHONE	# OF DEPENDENTS			EMPLOYMENT STATUS
				NCCI CLASS CODE
RATE PER:	DAY WEEK	MONTH OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?
				YES YES NO NO
OCCURRENCE/TREATMENT				
TIME EMPLOYEE BEGAN WORK	AM PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE () CANNOT BE DETERMINED	AM PM
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?		YES NO YES NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)		INITIAL TREATMENT
				0 NO MEDICAL TREATMENT
				1 MINOR: BY EMPLOYER
				2 MINOR CLINIC/HOSP
				3 EMERGENCY CARE
				4 HOSPITALIZED > 24 HOURS
				5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED
OTHER				
WITNESSES (NAME & PHONE #)				
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE		PHONE NUMBER