Iowa Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS Jurisdiction Code_____ Jurisdiction Claim Number_____

CLAIM ADMIN

Claim Administrator Name:	Claim Representative Business Phone Number:	Insurer Name (if different than claim administrator):
Mailing Address, City, State, & Postal Code:	Claim Administrator Claim Number:	Insurer FEIN:
	Claim Administrator FEIN:	Claim Type Code:

EMPLOYER

Employer Name:	Employer FEIN:	Insured Report Number:	Employer Type Code: __ Employer (E) __ Lessor (L)
Physical Address, City, State, & Postal Code:	Mailing Address, City, State, & Postal Code:	Industry Code:	
		Insured Location Number:	Employer UI Number:
Nature of Business:	Employer Contact Name and Business Phone Number:		

POLICY

Insured Name (parent company if different than employer):	Insured FEIN:	Insured Postal Code:	Policy/Contract Number:	Coverage Effective Date: Coverage Expiration Date:	Self Insurance License/ Certificate Number:

EMPLOYEE

Employee Name (First, Middle, Last, & Suffix):	Date of Birth:	Gender: __ Male (M) __ Female (F)	Tax Filing Status (check one): ____ Single (A) ____ Single/Head of Household (B) ____ Married/Filing Joint (C) ____ Married/Filing Separate(D)	
Mailing Address, City, State, & Postal Code:	Date of Hire:	Educational Level (grade completed): _____ [GED = 12]		Marital Status: (check one) ___ Unmarried (U) ___ Married (M) ___ Separated (S)
Phone Number (include area code):	Employment Status (check one): ____ Piece Worker ____ Volunteer ____ Seasonal ____ Apprenticeship/Full-Time ____ Apprenticeship/Part-Time ____ Regular Employee/Full-Time ____ Part-Time ____ Other	Employee ID Number (check one): ID # _____ ____ Social Security Number ____ Employment VISA Number ____ Passport Number ____ Green Card ____ Employee ID Assigned by Jurisdiction		Employee's Authorization to Release the Following: Medical Records __ yes __ no Social Security Number __ yes __ no
Occupation Description:				
Manual Classification Code:				
Department Where Regularly Worked:				

WAGE

Average Wage $ _____ (check one): ___ hourly ___ daily ___ semi-monthly ___ monthly ___ bi-weekly ___ annual ___ weekly	Salary Continued In Lieu of Compensation: ___ yes ___ no	Employee Number of Dependents: _____
	Full Wages Paid for Date of Injury: ___ yes ___ no	Employee Number of Exemptions: _____ (check one) ___ Entitled ___ Withholding
Number of Days Regularly Worked Per Week: _____	Discontinued Fringe Benefits: $_____	

ACCIDENT/INJURY

_____ Date of Injury _____ Date Employer Had Knowledge of the Injury _____ Date Claim Administrator Had Knowledge of the Injury _____ Initial Date Last Day Worked _____ Initial Return to Work Date (if applicable) _____ Employee Date of Death (if applicable)	Describe the nature of the injury. (ex. amputation, burn, cut, fracture):
_____ Time of Injury _____ Time Employee Began Work	Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):
Pre-Existing Disability Code: ___ Yes ___ No ___ Unknown	Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):
Accident Premises Code: ___ Employer (E) ___ Lessee (L) ___ Other (X)	Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):
Accident Site Organization Name:	
Accident Site Street, City, State, & Postal Code:	Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties:
Accident Location Narrative (if no street address):	
Accident Site County/Parish:	Witness Name & Business Phone Number:

MEDICAL

Initial Treatment Code (check one): ___ no medical treatment (0) ___ minor/on-site treatment (1) ___ clinic/hospital visit (2) ___ emergency care (3) ___ hospitalization > 24 hours (4) ___ future medical treatment/lost time anticipated (5)	Initial Medical Provider Name:	Managed Care Organization Name or ID Number:
	Initial Medical Provider Physical Address, City, State, & Postal Code:	ICD Primary Diagnostic Code (if known):

Preparer's Name & Title:	Preparer's Company Name:	Phone Number:	Date:

This section is to provide information valuable in handling this claim.

The Iowa Occupational Safety and Health Act

The following is a summary of the recordkeeping, reporting and posting responsibilities of employers under Iowa's Occupational Safety and Health Act.

RECORDKEEPING REQUIREMENTS

Regulations issued under the Iowa Occupational Safety and Health Act of 1972 require establishments subject to the Act to maintain records of recordable occupational injuries and illness. Such records must consist of: (a) a log and summary of occupational injuries and illnesses and (b) a supplementary record of each occupational injury and illness.

LOG AND SUMMARY OF OCCUPATIONAL INJURIES AND ILLNESSES. Each recordable occupational injury and occupational illness must be entered on a log and summary of cases (0SHA Form No. 200) as early as practicable but no later than six working days after receiving information that a recordable case has occurred. A multi-unit employer may maintain the log and summary of occupational injuries and illnesses at a place other than the establishment if there is a copy of the log and summary available in the establishment complete and current to a date within 45 calendar days. If an equivalent of OSHA Form No 200 is used, such as a printout from data-processing equipment, the information shall be as readable and comprehensible to a person not familiar with the data-processing equipment as the OSHA Form No. 200 itself. Logs must be kept current and retained for 5 years following the end of the calendar year to which they relate.

SUPPLEMENTARY RECORD OF OCCUPATIONAL INJURIES AND ILLNESSES. To supplement the Log and Summary of Occupational Injuries and Illnesses, each employer must have available a record for each occupational injury or illness at each establishment within six working days after receiving information that a recordable case has occurred, OSHA Form No. 101 may be used for this purpose. State of Iowa Form No. 14-0001 [(IAIABC Form 1.2 (12/98)], workers' compensation or other reports are acceptable as records if they contain the information required on OSHA Form No 101. These records must be available in the establishment without delay and at reasonable times for examination by representatives of the Iowa Division of Labor Services, the U.S. Department of Labor and the U.S. Department of Health, Education and Welfare. The records must be maintained for a period of not less than 5 years following the end of the calendar year to which they relate.

ANNUAL SUMMARY. Each employer subject to the recordkeeping requirements must prepare a summary of the occupational injury and illness experience of the employees in each of the employer's establishments at the end of each year based on the information contained in the log and summary of occupational injuries and illnesses for the particular establishment. OSHA Form No. 200 shall be used for this purpose. The summary shall be signed and posted in a place accessible to the employees no later than February 1 and shall remain in place until March 1. For employees who do not report to work at a single establishment, or who do not report to any fixed establishment on a regular basis, employers shall satisfy the posting requirement by presenting or mailing a copy of the annual summary during the month of February to all such employees who receive pay during that month. Summaries must be retained for 5 years following the end of the calendar year to which they relate.

EMPLOYEES NOT IN FIXED ESTABLISHMENTS. Employers of employees engaged in physically dispersed operations such as occur in construction, installation, repair or service activities who do not report to any fixed establishment on a regular basis but are subject to common supervision may satisfy the recordkeeping provisions with respect to such employees by:

(a) Maintaining the required records for each operation or group of operations which is subject to common supervision (field superintendent, field supervision, etc.) in an established central place;

(b) Having the address and telephone number of the central place available at each worksite; and

(c) Having personnel available at the central place during normal business hours to provide information from the records maintained there by telephone and by mail.

(Note: This regulation does not automatically apply to all construction, installation, repair or service activities. If in doubt about applicability to your operations, contact the Iowa Division of Labor Services.)

Records for personnel who do not primarily report or work at a single establishment, and who are generally not supervised in their daily work, such as traveling salespersons, technicians, engineers, etc., shall be maintained at the location from which they are paid or the base from which personnel operate to carry out their activities.

REPORTING REQUIREMENTS

Regulations issued under the Iowa Occupational Safety and Health Act require all employers subject to the Act to report to the Iowa Workers' Compensation Commissioner any occupational injury or illness which temporarily disables an employee for more than three days or which results in permanent total disability, permanent partial disability, or death. The report must be filed electronically in conformity with EDI requirements with the Iowa Division of Workers' Compensation within four days from such event when the injury or illness is alleged by the employee to have been sustained in the course of the employee's employment. A report to the Iowa Division of Workers' Compensation is considered to be a report to the Iowa Division of Labor Services. The Iowa Division of Workers' Compensation shall forward all such reports to the Iowa Division of Labor Services.

In addition, employers must report to the Iowa Labor Commissioner within 8 hours each accident or health hazard that results in one or more fatalities or hospitalization of three or more employees.

Those establishments selected to participate in the annual Occupational Injuries and Illnesses Survey will be required to prepare a report (OSHA Form No 200-S) based on entries contained on the Log and Summary of Occupational Injuries and Illnesses.

POSTING REQUIREMENTS

The Iowa Occupational Safety and Health Act requires that employees be informed of the job safety and health protection provided under the Act. The poster, "Safety and Health Protection on the Job," is to be used for this purpose, and must be posted in a prominent place in the establishment to which the employees usually report to work. The poster briefly states the intent and coverage of the Act and the responsibilities of employers and employees to maintain safe and healthful working conditions.

EMPLOYERS WHO MUST KEEP OSHA RECORDS

Employers with 11 or more employees (at any one time in the previous calendar year) in the following industries must keep OSHA records. The industries are identified by name and by the appropriate Standard Industrial Classification (SIC) code:

- Agriculture, forestry, and fishing (SIC's 01-02 and 07-09)
- Oil and gas extraction (SIC 13 and 1477)
- Construction (SIC's 15-17)
- Manufacturing (SIC's 20-39)
- Transportation and public utilities (SIC's 41-42 and 44-49)
- Wholesale trade (SIC's 50-51)
- Building materials and garden supplies (SIC 52)
- General merchandise and food stores (SIC's 53 and 54)
- Hotels and other lodging places (SIC 70)
- Repair services (SIC's 75 and 76)
- Amusement and recreation services (SIC 79)
- Health services (SIC 80), and
- State and local government (Above SIC 's plus 91-97).

If employers in any of the industries listed above have more than one establishment with combined employment of 11 or more employees, records must be kept for each individual establishment.

All employers, including small employers and those in exempted SIC's, must continue to meet the requirement to report fatalities or multiple (3 or more) hospitalizations and all occupational injuries or occupational illnesses that result in a workers' compensation case.

If an employer is notified in writing by the Bureau of Labor Statistics about having been selected to participate in a statistical survey, such employer, including small employers, and those in exempted SIC's, must maintain a log and summary of all occupational injuries and illnesses for that year. The notification will contain the necessary form and instructions to comply with the survey requirements.

The Iowa Workers' Compensation Act

The following is a summary of the recordkeeping and reporting responsibilities of employers under the Iowa Workers' Compensation Act.

RECORDS AND REPORTS

Every employer shall keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day. An employer with notice or knowledge of an injury which temporarily disables an employee for more than three (3) days or results in permanent total disability, permanent partial disability or death is required to electronically file a report with the Workers' Compensation Commissioner within four (4) days from such event when such injury is alleged by the employee to have been sustained in the course of employment.

All books, records, and payrolls of an employer are required to be open for inspection by the Workers' Compensation Commissioner for purposes of administration of the Iowa Workers' Compensation Act.

The Workers' Compensation Commissioner may require an employer to appear and show cause why the employer should not be subject to a civil penalty of $1,000.00 per occurrence for failure to comply with the reporting or inspection requirements. Upon hearing, if the facts indicate, the commissioner may enter an order requiring payment of such penalty. Unless voluntarily paid, the commissioner may petition the district court for entry of judgment on the order. The employer's insurance carrier shall be responsible in the same manner and to the same extent as the employer when a report of injury has been submitted to the employer's insurance carrier and not filed by them with the Workers' Compensation Commissioner.

The employer is required to furnish to an employee, on request, one statement of earnings, wages, or salary for the year preceding the injury. An employer may be subject to a civil penalty of $1000.00 per offense for refusal to furnish such wage statement.

INSTRUCTIONS

An employer with notice or knowledge of an injury which temporarily disables an employee for more than THREE (3) days or results in permanent total disability, permanent partial disability or death is required to electronically file a first report of injury with the Iowa DIVISION OF WORKERS' COMPENSATION within **FOUR (4)** days from such event when such injury is **alleged** by the employee to have been sustained in the course of the employee's employment. A report to the Iowa DIVISION OF WORKERS' COMPENSATION is considered to also be a report to the Iowa DIVISION OF LABOR SERVICES. The Iowa DIVISION OF WORKERS' COMPENSATION forwards the report to the Iowa Division of Labor Services. Employers should report ALL injuries to their insurance carrier or third party administrator. **ALL REPORTS MUST BE FILLED IN COMPLETELY AND SIGNED. PLEASE TYPE OR PRINT LEGIBLY.**

This form contains all items requested on OSHA form No 101, "Supplementary Record of Occupational Injuries and Illness."

THE INFORMATION PROVIDED WILL BE OPEN FOR PUBLIC INSPECTION UNDER Iowa Code § 22.11.

IOWA WORKFORCE DEVELOPMENT

City of Council Bluffs

Employee Injury Report

Routing: Director _____
Division Sup. _____
Risk Manager _____
Human Resources _____
_____

Employee's name: _____ Male: ☐ Female: ☐

Date of birth: _____ Employment date: _____

Present dept./division/classification: _____

How long has the employee worked at the present classification? _____

Date of injury: _____ Time of injury: _____

Location of injury: _____ Was the employee on duty? _____

Was proper personal protective equipment used? Yes: ☐ No: ☐

Describe: _____

What were you doing when the injury occurred? What machine or tool were you using? What type of operation?

Describe bodily injury sustained (be specific about body part(s) affected). Mark area of injury on the body diagram below if needed:

Recommendation on how to prevent this accident from recurring:

Physician: _____ Hospital: _____

Time lost: _____ Work comp report: _____

Name of supervisor: _____ Phone: _____

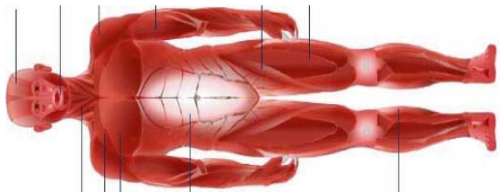
Name of witness(es): _____ Phone: _____

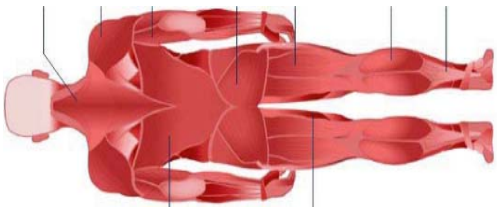
_____ Phone: _____

When did you report the accident to your supervisor? _____

To whom did you report the accident? _____

Signature of employee: _____ Date: _____





City of Council Bluffs

Supervisor Injury Investigation

Detail your reconstruction of the accident.

Describe unsafe condition(s).

Describe unsafe act(s).

Was the injury avoidable? _____

Action(s) suggested or taken to prevent reoccurrence:

Supervisor's name: _____ Phone: _____

Signature of supervisor: _____ Date: _____