

## WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

|                          |                                                                                                                                                                                              |                                                 |                            |                                                         |                                            |                                    |                                                                                                       |                                                                                                                                                                                                                                                                                                                            |                                               |                   |                             |     |                          |     |                            |    |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|---------------------------------------------------------|--------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------|-----------------------------|-----|--------------------------|-----|----------------------------|----|
| General                  | Employer (Name & Address incl. zip)                                                                                                                                                          |                                                 |                            |                                                         | Carrier Administrator Claim Number         |                                    |                                                                                                       |                                                                                                                                                                                                                                                                                                                            | Report Purpose Code                           |                   |                             |     |                          |     |                            |    |
|                          |                                                                                                                                                                                              |                                                 |                            |                                                         | Jurisdiction                               |                                    | Jurisdiction Claim Number                                                                             |                                                                                                                                                                                                                                                                                                                            |                                               |                   |                             |     |                          |     |                            |    |
|                          |                                                                                                                                                                                              |                                                 |                            |                                                         | Insured Report Number                      |                                    |                                                                                                       |                                                                                                                                                                                                                                                                                                                            |                                               |                   |                             |     |                          |     |                            |    |
|                          |                                                                                                                                                                                              |                                                 |                            |                                                         | Employer's Location Address (if different) |                                    |                                                                                                       |                                                                                                                                                                                                                                                                                                                            |                                               |                   | Location No.                |     |                          |     |                            |    |
|                          | Sic Code                                                                                                                                                                                     |                                                 | Employer FEIN              |                                                         | Phone No.                                  |                                    |                                                                                                       |                                                                                                                                                                                                                                                                                                                            |                                               |                   |                             |     |                          |     |                            |    |
| Carrier/Claims Admin     | Carrier (Name, Address & Phone Number)                                                                                                                                                       |                                                 |                            |                                                         | Policy Period                              |                                    | Claims Admin (Name, Address & Phone Number)                                                           |                                                                                                                                                                                                                                                                                                                            |                                               |                   |                             |     |                          |     |                            |    |
|                          |                                                                                                                                                                                              |                                                 |                            |                                                         | to                                         |                                    |                                                                                                       |                                                                                                                                                                                                                                                                                                                            |                                               |                   |                             |     |                          |     |                            |    |
|                          |                                                                                                                                                                                              |                                                 |                            |                                                         | <input type="checkbox"/>                   | Check if self insured              |                                                                                                       |                                                                                                                                                                                                                                                                                                                            |                                               |                   |                             |     |                          |     |                            |    |
|                          |                                                                                                                                                                                              |                                                 |                            |                                                         | Carrier FEIN                               |                                    | Policy Number or Self-Insured Number                                                                  |                                                                                                                                                                                                                                                                                                                            |                                               |                   | Administrator FEIN          |     |                          |     |                            |    |
| Agent Name & Code Number |                                                                                                                                                                                              |                                                 |                            |                                                         |                                            |                                    |                                                                                                       |                                                                                                                                                                                                                                                                                                                            |                                               |                   |                             |     |                          |     |                            |    |
| Employee/Injured         | Legal Name (Last, First, Middle)                                                                                                                                                             |                                                 |                            |                                                         | Date of Birth                              |                                    | Social Security Number                                                                                |                                                                                                                                                                                                                                                                                                                            |                                               |                   | Date Hired                  |     | State of Hire            |     |                            |    |
|                          | Address (incl. zip)                                                                                                                                                                          |                                                 |                            |                                                         | Sex                                        |                                    | Marital Status                                                                                        |                                                                                                                                                                                                                                                                                                                            | Occupation/Job Title                          |                   |                             |     |                          |     |                            |    |
|                          |                                                                                                                                                                                              |                                                 |                            |                                                         | <input type="checkbox"/> Male              | <input type="checkbox"/> Female    | <input type="checkbox"/> Unmarried/Single/Div.                                                        | <input type="checkbox"/> Married                                                                                                                                                                                                                                                                                           |                                               |                   |                             |     |                          |     |                            |    |
|                          |                                                                                                                                                                                              |                                                 |                            |                                                         | <input type="checkbox"/> Unknown           | <input type="checkbox"/> Separated |                                                                                                       |                                                                                                                                                                                                                                                                                                                            |                                               |                   |                             |     |                          |     |                            |    |
|                          | Phone                                                                                                                                                                                        |                                                 |                            |                                                         | No. of Dependents                          |                                    | Unknown                                                                                               |                                                                                                                                                                                                                                                                                                                            | NCCI Class Code                               |                   |                             |     |                          |     |                            |    |
|                          | Wage Rate                                                                                                                                                                                    |                                                 | <input type="checkbox"/>   | Day                                                     | <input type="checkbox"/>                   | Month                              | if days involved                                                                                      |                                                                                                                                                                                                                                                                                                                            | Full Pay for Date of                          |                   | <input type="checkbox"/>    | Yes | <input type="checkbox"/> | No  |                            |    |
|                          | \$                                                                                                                                                                                           |                                                 | <input type="checkbox"/>   | Week                                                    | <input type="checkbox"/>                   | Other                              | if hrs worked per day                                                                                 |                                                                                                                                                                                                                                                                                                                            | Did Salary Continue?                          |                   | <input type="checkbox"/>    | Yes | <input type="checkbox"/> | No  |                            |    |
| Occurrence               | Time Employee Began Work                                                                                                                                                                     |                                                 | <input type="checkbox"/> A | Date of Injury or Illness                               |                                            | Time Occurred                      |                                                                                                       | <input type="checkbox"/> A                                                                                                                                                                                                                                                                                                 | Last Work Date                                |                   | Date Employer Notified      |     | Date Disability Began    |     |                            |    |
|                          | <input type="checkbox"/> P                                                                                                                                                                   |                                                 |                            |                                                         |                                            |                                    | <input type="checkbox"/> P                                                                            |                                                                                                                                                                                                                                                                                                                            |                                               |                   |                             |     |                          |     |                            |    |
|                          | Employer Contact Name/Phone Number                                                                                                                                                           |                                                 |                            |                                                         |                                            |                                    | Type of Illness/Injury                                                                                |                                                                                                                                                                                                                                                                                                                            |                                               |                   | Part of Body Affected       |     |                          |     |                            |    |
|                          | Did Injury/Illness Exposure Occur on Employer's Premises?                                                                                                                                    |                                                 |                            |                                                         |                                            |                                    | Yes <input type="checkbox"/>                                                                          |                                                                                                                                                                                                                                                                                                                            | No <input type="checkbox"/>                   |                   | Type of Illness/Injury 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 Returned to                                                                                                                                                                             |                                                 |                            |                                                         | if Fatal, Date of Death                    |                                    |                                                                                                       |                                                                                                                                                                                                                                                                                                                            | Were Safeguards or Safety Equipment Provided? |                   |                             |     | <input type="checkbox"/> | Yes | <input type="checkbox"/>   | No |
|                          |                                                                                                                                                                                              |                                                 |                            |                                                         |                                            |                                    |                                                                                                       |                                                                                                                                                                                                                                                                                                                            | Were they used?                               |                   |                             |     | <input type="checkbox"/> | Yes | <input type="checkbox"/>   | No |
|                          | Treatment                                                                                                                                                                                    | Physician/Health Care Provider (Name & Address) |                            |                                                         |                                            | Hospital (Name & Address)          |                                                                                                       |                                                                                                                                                                                                                                                                                                                            |                                               | Initial Treatment |                             |     |                          |     |                            |    |
|                          |                                                                                                                                                                                              |                                                 |                            |                                                         |                                            |                                    |                                                                                                       | <input type="checkbox"/> 0 No Medical Treatment<br><input type="checkbox"/> 1 Minor: By Employer<br><input type="checkbox"/> 2 Minor Clinic/Hosp<br><input type="checkbox"/> 3 Emergency Care<br><input type="checkbox"/> 4 Hospitalized > 24 hr.<br><input type="checkbox"/> 5 Future Major Medical/Lost Time Anticipated |                                               |                   |                             |     |                          |     |                            |    |
| Other                    | Witness to Accident (Name & Phone Number)                                                                                                                                                    |                                                 |                            |                                                         |                                            |                                    |                                                                                                       |                                                                                                                                                                                                                                                                                                                            |                                               |                   |                             |     |                          |     |                            |    |
|                          | Date Administrator Notified                                                                                                                                                                  |                                                 |                            |                                                         | Date Prepared                              |                                    | Preparer's Name & Title                                                                               |                                                                                                                                                                                                                                                                                                                            |                                               |                   | Preparer's Phone Number     |     |                          |     |                            |    |
| IA-1 (2/95)              |                                                                                                                                                                                              |                                                 |                            | SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE |                                            |                                    |                                                                                                       |                                                                                                                                                                                                                                                                                                                            |                                               |                   |                             |     |                          |     |                            |    |

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## **Table of Contents Kentucky First Report Of Injury Form**

1. Understanding the eBook Kentucky First Report Of Injury Form
  - The Rise of Digital Reading Kentucky First Report Of Injury Form
  - Advantages of eBooks Over Traditional Books
2. Identifying Kentucky First Report Of Injury Form
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Kentucky First Report Of Injury Form
  - User-Friendly Interface

4. Exploring eBook Recommendations from Kentucky First Report Of Injury Form
  - Personalized Recommendations
  - Kentucky First Report Of Injury Form User Reviews and Ratings
  - Kentucky First Report Of Injury Form and Bestseller Lists
5. Accessing Kentucky First Report Of Injury Form Free and Paid eBooks
  - Kentucky First Report Of Injury Form Public Domain eBooks
  - Kentucky First Report Of Injury Form eBook Subscription Services
  - Kentucky First Report Of Injury Form Budget-Friendly Options
6. Navigating Kentucky First Report Of Injury Form eBook Formats
  - ePub, PDF, MOBI, and More
  - Kentucky First Report Of Injury Form Compatibility with Devices
  - Kentucky First Report Of Injury Form Enhanced eBook Features
7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Kentucky First Report Of Injury Form
  - Highlighting and Note-Taking Kentucky First Report Of Injury Form
  - Interactive Elements Kentucky First Report Of Injury Form
8. Staying Engaged with Kentucky First Report Of Injury Form
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Kentucky First Report Of Injury Form
9. Balancing eBooks and Physical Books Kentucky First Report Of Injury Form
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Kentucky First Report Of Injury Form
10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
11. Cultivating a Reading Routine Kentucky First Report Of Injury Form
  - Setting Reading Goals Kentucky First Report Of Injury Form
  - Carving Out Dedicated Reading Time

12. Sourcing Reliable Information of Kentucky First Report Of Injury Form
  - Fact-Checking eBook Content of Kentucky First Report Of Injury Form
  - Distinguishing Credible Sources
13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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function showhint str if str length 0 document getelementbyid txthint innerhtml return else var xml new xmlhttprequest xml  
onreadystatechange function if this readystate 4 this status 200 document getelementbyid txthint innerhtml this responsetext

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first name suggestions example explained in the example above when a user types a character in the input field a function called showhint is executed the function is triggered by the onkeyup event here is the html code example html head script  
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