Instructions for Completing the Iowa First Report of Injury

GENERAL INFORMATION

- ***Dates*** - Enter all dates in MM/DD/CCYY format.
- ***Addresses*** - Enter street address, city, state and postal code (9 digits, if known).
- ***Names*** - Enter all names first name, middle initial, last name, and last name suffix (Jr., Sr., etc., if applicable).
- ***FEIN's*** - Enter the Federal Employer Identification Number of the entity.
- ***Phone Numbers*** - Enter the area code and telephone number (include extension, if applicable).
- ***Employee*** - The individual about whom this form is being filed.
- ***Jurisdiction Code*** – Please use "IA" or "19" to represent the codes used for Iowa.
- ***Jurisdiction Claim #*** - The number assigned by the jurisdiction to identify this claim.
- ***Claim Type Code*** - Enter one of the following codes which represents the current benefit classification of the claim according to jurisdictional requirements:

M	Medical only	**I**	Indemnity	**N**	Notification only
B	Became medical only	**L**	Became lost time	**T**	Transfer (claim jurisdiction changed)

CLAIM ADMINISTRATOR:

- ***Claim Administrator Name*** - Enter the name of the carrier, third party administrator, or self-insured responsible for administering the claim. (Refers to question 8 on prior Iowa form).
- ***Claim Administrator Claim #*** - An identifier which distinguishes a specific claim within a claim administrator's claims processing system assigned by the claim administrator.
- ***Insurer Name*** - The legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim.

EMPLOYER:

- ***Physical Address*** - Enter the address of the employer's facility where the employee was employed at the time of injury. See Accident Site Information question. (Refers to question 2 on prior Iowa form).
- ***Mailing Address*** – Enter the employer's mailing address. (Refers to question 1 on prior Iowa form).
- ***Employer Contact Name*** - Enter the name of the individual at the employer's premises to be contacted for additional information.
- ***Nature of Business*** - Enter the narrative description of the nature of the employer's business related to the specific business operation for which the employee was employed at the time of injury. (Refers to question 3 on prior Iowa form).
- ***Insured Report Number*** - Enter a number that may be assigned by the insured to identify a specific claim. This may be the OSHA 101 number. If no number is assigned, this may be left blank.
- ***Industry Code*** - The code, which represents the nature of the employer's business which may be found in either the Standard Industrial Classification Manual (SIC) or the North American Industrial Classification System (NAICS).
- ***Employer Type Code*** – A code that indicates whether the employer for whom the employee worked at the time of the injury is a lessor. If the employee is paid directly by the employer, check E. If the employee is paid by a leasing company, check L.
  NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.
- ***Employer UI Number*** - Enter the unemployment insurance number assigned for each employer by the state unemployment agency.
- ***Insured Location Number*** - Enter a code defined by the insured which is used to identify the employer's location of the accident. If there is no number, this should be left blank.

POLICY:

- ***Insured Name*** - Indicate the named entity of the policy. (Refers to question 7 on prior Iowa form).
- ***Policy/Contract Number*** - Enter number identifying the coverage policy in effect for the claim. (Refers to question 52 on prior Iowa form).
- ***Coverage Effective Date*** - Enter the date that the employer's insurance policy or self-insurance license/certificate became effective. (Refers to question 50 on prior Iowa form).
- ***Coverage Expiration Date*** - Enter the date that the employer's insurance policy or self-insurance license/certificate expired. (Refers to question 51 on prior Iowa form).

EMPLOYEE:

- ***Employee Name*** - Indicate the employee's legally recognized name. (Refers to question 9 on prior Iowa form).
- ***Occupation Description*** - Indicate the primary occupation of the employee at the time of the accident or injurious exposure. (Refers to question 14 on prior Iowa form).
- ***Date of Hire*** - Provide the date the employee began his/her employment with the specified employer. If there have been multiple periods of employment, the beginning date of the current employment period should be indicated. (Refers to question 13 on prior Iowa form).
- ***Manual Classification Code*** - Provide the code that corresponds to the primary occupation in which the employee was engaged at the time of accident/injury, or injurious exposure, if known.
- ***Employment Status*** - Indicate the employee's work status at the time of injury. In the event that multiple Employment Status Codes apply to the employee, use the following hierarchy to determine which status, the topmost, to report. (i.e., if employee is a part time seasonal worker, report as seasonal worker.) (Refers to question 42 on prior Iowa form).

  1. **Piece Worker** - the injured employee was paid for employment according to the number of products/services completed or number of trips completed.
  2. **Volunteer** - the injured employee was serving at one's own free will without legal obligation of payment.
  3. **Seasonal** - the injured employee was employed in a position dependent on or controlled by the season of the year.
  4. **Apprenticeship Full-Time** - the injured employee was bound by a legal agreement to work full-time for another in return for instruction in a trade or occupation.

5 **Apprenticeship Part-Time** - the injured employee was bound by a legal agreement to work part-time for another in return for instruction in a trade or occupation.
6 **Regular Employee Full Time** - the injured employee was employed on a full-time basis. (schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time). This status is NOT used when reporting experience for full-time seasonal, volunteer, apprenticeship, or piece workers.
7 **Part-time** - the injured employee was employed on a part-time basis (whose work history in the preceding months shows that the person worked on less than a full- time basis). This status is NOT used when reporting experience for part-time seasonal, volunteer, apprenticeship or piece workers.
8 **Other** - the injured employee had an employment status at the time of injury other than those previously listed.

- ***Marital Status*** - U = Widowed, Divorced, Single, Unmarried. (Refers to question 36 on prior Iowa form).

- ***Tax Filing Status*** - Indicate the employee's federal tax filing status used on the Internal Revenue tax forms.
  NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Employee ID Number*** - SSN is preferred. Critical to matching existing claims. If no SSN, please contact Iowa DWC. (Refers to question 10 on prior Iowa form).

- ***Education level*** - Indicate the highest number of years or equivalency level of formal education completed.
  (High school graduate/GED = 12)

- ***Employee Authorization to Release***: *NOTE*: Iowa Division of Workers' Compensation will not collect this information at this time.
  Medical - Indicate whether the employee has provided written authorization to release medical records related to the injury.
  SSN - Indicate whether the employee has provided a written authorization to release the employee's Social Security Number.

WAGE:

- ***Salary Continued in Lieu of Compensation*** - The status of whether the employer is currently paying the employee's salary in lieu of compensation caused by a work related injury.

- ***Number of Dependents*** - *NOTE*: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Number of Entitled Exemptions*** - The maximum number of exemptions that the employee is entitled to claim on their annual Federal Income Tax. Exemptions include marital status, maximum exemptions employee can claim (e.g. self, 65 and over, blind, spouse, etc.), number of dependent children, and other dependents. Refer to questions 36 & 37 on prior Iowa form).

- ***Number of Withholding Exemptions*** - The number of exemptions that the employee claims on their withholding information provided to the employer.
- *NOTE*: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Average Wage*** - The employee's pre-injury wage for the wage period as statutorily defined by the jurisdiction. The amount may include commissions, piecework earnings and other forms of income converted to a normal scheduled work wee, plus the estimated value of lodging, food, laundry and other payments in kind, as per jurisdictional requirements. Average wage includes discontinued fringes and concurrent employer wages, if any. It is preferred that hourly wage be calculated into a weekly wage. (Refers to question 38 - 42 on prior Iowa form).

ACCIDENT/INJURY:

- ***Time*** - indicate the time military format 00:00 through 23:59 for:
  - ***of Injury*** (Refers to question 22 on prior Iowa form).
  - ***Employee began work*** (Refers to question 23 on prior Iowa form).

- ***Initial Date Last Day Worked*** - Enter the last day the employee was able to work prior to the original lost time from work due to the occupational injury or disease. This date may be the date of injury or the first date prior to the initial lost time.

- ***Initial Return to Work Date*** - Enter the date following the first disability period on which the employee returned to work.

- ***Accident Premises Code*** - Check the code that indicates the premises on which the accident occurred.

- ***Accident Site Information*** - If accident site is different than the Employer Physical Address, then the accident site address information must be completed. For ease of description, Accident Site Address formatting has been developed. (Refers to question 5 on prior Iowa form).

MEDICAL:

- ***Initial Treatment Code*** - Select one of the six choices listed on the form. The choice should indicate the initial treatment only that the injured worker received immediately after the injury. If none, select "No medical treatment". The intent is to reflect care rendered at the time of reporting. Not anticipated care or severity of injury at the time of initial report.

- ***Initial Medical Provider*** - Name of the physician, clinic, hospital or in house treatment provider at the time of the report. (Refers to question 45-47 on prior Iowa form).

- ***Managed Care Organization Name or ID Number*** – *NOTE*: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Primary ICD Diagnostic Code*** - This is only needed if medical treatment was rendered. The medical provider should determine the selected code. If code is provided, enter the ICD (International Classification of Diagnosis or Disease) code depending on jurisdictional requirements at the time of injury.
  NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.