

# First Report of Injury or Illness (FROI)

Submit by one of these methods: Mail to State Insurance Fund, PO Box 83720, Boise, ID 83720-0044,  
upload as an attachment at [www.idahosisif.org](http://www.idahosisif.org), email as an attachment to [reportclaim@idahosisif.org](mailto:reportclaim@idahosisif.org), or fax to 208-332-8160

|   |   |   |   |   |  |  |
|---|---|---|---|---|--|--|
| Every work injury that requires medical services other than first aid treatment must be reported within TEN days after the employer has knowledge of the injury. Filing this form is not an admission of liability. This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made. |   |   |   |   |  |  |
| <b>E<br/>M<br/>P<br/>L<br/>O<br/>Y<br/>E<br/>R</b>  | Submission type: <input type="checkbox"/> New Claim <input type="checkbox"/> Revised Claim Claim number (if revised):   |   |   | Date prepared:  |  |  |
|   | Employer's name:  |   |   | Entity Type:  |  |  |
|   | Address:  |   |   | <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> LLC                              |  |  |
|   | City:   | State:  | ZIP:  | <input type="checkbox"/> Partnership <input type="checkbox"/> Public <input type="checkbox"/> Other                                     |  |  |
|   | Country:  |   |   | Is injured worker a Corporate Officer, Partner, LLC member or Sole Proprietor? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|   | Employer's location address:  |   |   |   |  |  |
| <b>E<br/>M<br/>P<br/>L<br/>O<br/>Y<br/>E<br/>R</b>  | City:   | State:  | ZIP:  | If a Sole Proprietor or LLC, is the injured worker a household member? <input type="checkbox"/> Yes <input type="checkbox"/> No         |  |  |
|   | Country:  | Policy #:   | FEIN:   |   |  |  |
|   | Phone:  | Email:  | Organization code:  |   |  |  |
|   |   |   |   |   |  |  |
| <b>E<br/>M<br/>P<br/>L<br/>O<br/>Y<br/>E<br/>E</b>  | Last name:  |   | Suffix:   | State where hired:  |  |  |
|   | First name:   |   | MI:   | Occupation:   |  |  |
|   | Address:  |   |   | Employment status:  |  |  |
|   | City:   | State:  | ZIP:  | Social Security # or Federal ID#:   |  |  |
|   | Country:  | Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown |   | Fed ID Type:  |  |  |
|   | Phone:  | Date of birth:  |   | Date hired:   |  |  |
|   | Class code wages reported:  | W2 Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No                               |   | Injury date:  |  |  |
|   | Regular job/dept.:  |   | Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown |   |  |  |
|   | Wage rate: _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Other... explain: |   |   |   |  |  |
|   | Hours worked per week: <input type="checkbox"/> Steady <input type="checkbox"/> Variable  |   |   | Days worked per week: <input type="checkbox"/> Steady <input type="checkbox"/> Variable   |  |  |
| Full pay for the day of injury: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, how many hours paid for the day of injury?  |   |   |   | Did salary continue? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| Comments on hours/days worked:  |   |   |   |   |  |  |
| Avg. weekly value of board (lodging, meals, etc.) received in addition to wages:  |   |   | Avg. weekly value of gratuities (tips, etc.) received:  |   |  |  |
| <b>A<br/>C<br/>C<br/>I<br/>D<br/>E<br/>N<br/>T</b>  | Place of accident/exposure (address):   |   |   | City:   |  |  |
|   | State:  | ZIP:  | County:   | Country:  |  |  |
|   | Did injury/illness occur on the employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No   |   | Time of injury: _____ AM _____ PM   | Time employee began work: _____ AM _____ PM   |  |  |
|   | Date last worked:   | Date employer notified:   | Injury reported to:   |   |  |  |
| <b>E<br/>M<br/>P<br/>L<br/>O<br/>Y<br/>E<br/>E</b>  | Date returned to work:  | Date disability began:  | If fatal, date of death:  |   |  |  |
|   | Part(s) of body affected:   | Side of body:   | Body part injured before: <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
|   | Injury type (strain, cut, etc.):  |   |   |   |  |  |
|   | Equipment, materials, or chemicals employee was using upon occurrence:  |   |   |   |  |  |
| <b>O<br/>R<br/>I<br/>G<br/>I<br/>N<br/>A<br/>L</b>  | How injury or illness occurred:   |   |   |   |  |  |
|   | Was accident caused by the failure of a machine or product? <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   | Was safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
|   | Was the accident caused by any person or business other than the injured worker, co-worker, or the employer? Yes No Please identify:  |   |   | Was it used? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
|   |   |   |   | Were other workers also injured? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>List other workers' names:                 |  |  |
| Witnesses to the accident: (name & phone):  |   |   |   |   |  |  |
| <b>M<br/>E<br/>D<br/>I<br/>C<br/>A<br/>L<br/>P<br/>R<br/>O<br/>V<br/>I<br/>D<br/>E<br/>R</b>  | Medical Provider name & address:  |   | <input type="checkbox"/> No medical treatment <input type="checkbox"/> Minor by employer  |   |  |  |
|   |   |   | <input type="checkbox"/> Minor - clinic/hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized overnight  |   |  |  |
| Anticipated major medical/time loss: <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |   |  |  |
| <b>P<br/>R<br/>E<br/>S<br/>E<br/>N<br/>T</b>  | Name and title:   |   | Role: <input type="checkbox"/> Employer <input type="checkbox"/> Injured worker <input type="checkbox"/> Insurance Agent <input type="checkbox"/> Attorney <input type="checkbox"/> Medical Provider                    |   |  |  |
|   | Phone:  | Email:  | Prefer contact by: <input type="checkbox"/> Phone <input type="checkbox"/> Email  |   |  |  |
| <b>A<br/>D<br/>D<br/>I<br/>T<br/>I<br/>O<br/>N<br/>A<br/>L</b>  | Do you question the claim? Yes No   |   |   |   |  |  |
|   | Comments:   |   |   |   |  |  |

**As the employer's representative, SIF will submit the FROI to the Industrial Commission. Keep a copy for your records.**