

WORKER'S COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

GENERAL	EMPLOYER (NAME & ADDRESS INCL ZIP) University of Arkansas for Medical Sciences 4301 West Markham St., #564 Little Rock, AR 72205				CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE									
	SIC CODE		EMPLOYER FEIN 71-6046242		JURISDICTION		JURISDICTION CLAIM NUMBER									
	INSURED REPORT NUMBER NA				EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #									
	PHONE #															
CARRIER ADMIN	CARRIER (NAME, ADDRESS & PHONE NO.) Public Employee Claims Division Arkansas Insurance Department 1200 West Third Street, Suite 201 Little Rock, AR 72201-1904				POLICY PERIOD INDEFINITE TO		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.) SAME AS CARRIER									
	CARRIER FEIN		POLICY/SELF-INSURED NUMBER NA				ADMINISTRATOR FEIN									
	AGENT NAME & CODE NUMBER NA				CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE											
EMPLOYEE	NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE AR						
	ADDRESS (INCL ZIP)			SEX M MALE F FEMALE U UNKNOWN		MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN		OCCUPATION/JOB TITLE		EMPLOYMENT STATUS						
	PHONE			# OF DEPENDENTS		NCCI CLASS CODE										
WAGE	RATE		PER: DAY WEEK		MONTH OTHER:		#DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		YES NO					
									DID SALARY CONTINUE?		YES NO					
OCCURRENCE	TIME EMPLOYEE BEGAN WORK		AM PM		DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE CANNOT BE DETERMINED		AM PM		LAST WORK DATE		DATE EMPLOYER NOTIFIED		DATE DISABILITY BEGAN	
	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 checked="" 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 RETURNED TO WORK				IF FATAL, GIVE DATE OF DEATH				WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?				YES NO			
													YES NO			
TREATMENT	PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)						HOSPITAL OR OFFSITE TREATMENT (NAME & ADDRESS)				INITIAL TREATMENT					
											0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSPITAL 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED					
OTHER	WITNESS TO ACCIDENT (NAME & PHONE #)															
	DATE ADMINISTRATOR NOTIFIED				DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER					

Form 1	ARKANSAS WORKER'S COMPENSATION COMMISSION Form 1 (Employer's First Report of Injury or Illness)
Ark. Code Ann. §§11-9-529 AWCC Rule 33 Revised: 1/1/2001	Ark. Code Ann. § 11-9-529 allows employers 10 days to report injuries. Those involving either more than 7 days of lost time or indemnity payments require Form 1 . Also, a Form 1 is required for all controversies including a medical-only case. Self-insured employers file Form 1 with the AWCC; other employers send it to their insurance representatives.

Employers do **NOT** fill in the shaded areas.

<p>On Form 1, employers/carriers must:</p> <ol style="list-style-type: none"> (1) In the Occurrence Section list the date the employer first knew of the injury. The 10 days to report begin either on the date of disability or the date the employer was notified, whichever date is later. (2) Give the name of the carrier. An insurance agency or third party administrator should be listed in the Preparer's Section. A carrier can pre-print its name and address in the Carrier Section to help clients properly report. (3) Specify the carrier Federal Employer Identification Number (FEIN) in the Carrier Section. (4) Type or <u>print in ink</u>. An illegible, incomplete Form 1 will be returned. <p>Neglect of Form 1: Late employee benefits, exposing employers to fines.</p> <p>Lack of Form 1: Delays in insurance investigation.</p>
--

General inquiries on Form 1 can be answered by AWCC Support Services Division. Questions on a specific Form 1 may be directed to the Research and Statistics Section, which processes the accident reports. (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. § 11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Worker's Compensation Commission."