Iowa Division of Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS (FROI) **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: ☐ Transgender (T) ☐ Male (M) ☐ Non-Binary (X) ☐ Female (F) ☐ Unknown(U)	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:	State of Hire: / Educational Level (grade completed): _____ [GED = 12]	Marital Status: (check one) ☐ Unmarried/Single/Divorced (U) ☐ Married (M) ☐ Separated (S)
Email:	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
Phone Number (include area code):			
Occupation Description:			
NCCI 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)	Type of Injury / Illness Code:
	Describe the nature of the injury. (ex. amputation, burn, cut, fracture):
	Part of Body Affected Code:
_____ 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) ☐ Other (X) ☐ Lessee (L) ☐ Employee Residence (R)	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:

IOWA DIVISION OF WORKERS' COMPENSATION

www.IowaWorkComp.gov

First Report of Injury or Illness Requirement

An employer or the employer's representative must file with the Iowa Division of Workers' Compensation (DWC) a First Report of Injury or Illness (FROI) in case of occupational:

- Fatality,
- Permanent disability, or
- Temporary disability lasting more than three days.

An employer or the employer's representative must file a FROI within four days of the event.

An employer or the employer's representative must file a FROI if the employee claims the disability is caused by work even if the employer or employer's representative disagrees.

For more information on these and other requirements, go to: www.iowaworkcomp.gov

Records and Reports

Every employer must keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day.

All books, records, and payrolls of an employer must be open for inspection by the Iowa Workers' Compensation Commissioner for purposes of administering the Iowa Workers' Compensation Act.

An employer must furnish to an employee upon request one statement of earnings, wages, or salary for the year preceding the injury. An employer may be subject to a civil penalty of $1,000.00 per offense for failure to furnish such wage statement.

Civil Penalty

The Commissioner may require an employer to appear and show 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 it with the agency.

Additional Iowa OSHA Reporting Requirements

Additional reporting and recordkeeping requirements may apply to the incident described in the FROI.

An employer must:

- Report a workplace fatality to Iowa OSHA within eight hours by calling 877-242-6742 or visiting www.iowaosha.gov for a form and instructions.
- Report a hospitalization, loss of an eye, or amputation within twenty-four hours by calling 877-242-6742 or visiting www.iowaosha.gov for a form and instructions.
- Complete an OSHA Form 301, or equivalent for recordable, work-related incidents within seven days and retain the completed form on site. The FROI is equivalent to the OSHA Form 301 if the case number from the OSHA 300 log is added. For more information, go to: www.osha.gov/recordkeeping
- Make an entry in your Log of Work-Related Injuries and Illnesses, OSHA Form 300, for recordable cases within seven days and retain the completed form on site. Some industries are exempt from this requirement. For more information, go to: www.osha.gov/recordkeeping

For more information on these and other OSHA requirements, go to: www.iowaosha.gov