

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General	Employer (Name & Address incl. zip) Northwest Youth Corps 2621 Augusta Street Eugene OR 97403				Carrier/Administrator Claim Number		Report Purpose Code																						
					Jurisdiction		Jurisdiction Claim No.																						
	Insured Report No.																												
	Employer's Location Address (if different)						Location No.																						
NAICS Code 115310				Employer FEIN 93-0818160				Phone No.																					
Carrier/Claims Admin	Carrier (Name, Address & Phone Number) Zurich American Insurance Company 13810 FNB Parkway PO Box 542003 Omaha, NE 68154				Policy Period		Claims Admin (Name, Address & Phone Number)																						
					07/01/2020																								
	To 07/01/2021		<input type="checkbox"/> Check if self insured																										
Carrier FEIN			Policy Number or Self-Insured Number 452061			Administrator FEIN																							
Agent Name & Code Number AOL- 15594-000																													
Employee	Legal Name (Last, First, Middle)			Birth Date		Social Security Number		Date Hired		State of Hire																			
	Address (Incl. Zip)			Sex		Marital Status		Occupation/Job Title																					
				<input type="checkbox"/> Male		<input type="checkbox"/> Unmarried/Single/Div.		Employment Status																					
				<input type="checkbox"/> Female		<input type="checkbox"/> Married																							
	Phone			<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		NCCI Class Code																					
No. of Dependents				<input type="checkbox"/> Unknown																									
Wage Rate \$		<input type="checkbox"/> Day <input type="checkbox"/> Week		<input type="checkbox"/> Month <input type="checkbox"/> Other		# Days Worked/WK # Hrs Worked per Day		Full Pay for Date of Injury? Did Salary Continue?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No																			
Time Employee Began Work		<input type="checkbox"/> AM <input type="checkbox"/> PM		Date of Injury or Illness		Time Occurred		<input type="checkbox"/> AM <input type="checkbox"/> PM		Last Work Date		Date Employer Notified		Date Disability Began															
Employer Contact Name/Phone Number NYC- Jessica Johnson, 541-654-4712						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 Using upon Occurrence																							
Specific Activity Employee Engaged in at Time of Occurrence						Work Process the Employee Was Engaged in at Time of Occurrence																							
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, 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																				
									<table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px; text-align: center;">0</td><td><input type="checkbox"/></td><td>No Medical Treatment</td></tr> <tr><td style="width: 20px; text-align: center;">1</td><td><input type="checkbox"/></td><td>Minor: By Employer</td></tr> <tr><td style="width: 20px; text-align: center;">2</td><td><input type="checkbox"/></td><td>Minor Clinic/Hosp</td></tr> <tr><td style="width: 20px; text-align: center;">3</td><td><input type="checkbox"/></td><td>Emergency Care</td></tr> <tr><td style="width: 20px; text-align: center;">4</td><td><input type="checkbox"/></td><td>Hospitalized – 24 hr.</td></tr> <tr><td style="width: 20px; text-align: center;">5</td><td><input type="checkbox"/></td><td>Anticipated Major Med/Lost Time</td></tr> </table>				0	<input type="checkbox"/>	No Medical Treatment	1	<input type="checkbox"/>	Minor: By Employer	2	<input type="checkbox"/>	Minor Clinic/Hosp	3	<input type="checkbox"/>	Emergency Care	4	<input type="checkbox"/>	Hospitalized – 24 hr.	5	<input type="checkbox"/>
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4	<input type="checkbox"/>	Hospitalized – 24 hr.																											
5	<input type="checkbox"/>	Anticipated Major Med/Lost Time																											
Other	Signature of Injured Employee, or Signature on File, Date				Witness to Accident (Name & Phone Number)																								
	Date Administrator Notified			Date Prepared		Preparer's Name & Title				Preparer's Phone Number																			

Filing this report 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. Idaho Industrial Commission, P.O. Box 83720, Boise, ID 83720-0041 IC Form IA-1 (08/2013)