

# 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 M P L O Y E 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: <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Public <input type="checkbox"/> Other
	Address:		
	City:	State:	ZIP:
	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:		If a Sole Proprietor or LLC, is the injured worker a household member? <input type="checkbox"/> Yes <input type="checkbox"/> No
	City:	State:	
Country:	Policy #:	FEIN:	
Phone:		Email:	Organization code:
<b>E M P L O Y E E</b>	Last name:		Suffix:
	First name:		MI:
	Address:		State where hired:
	City:	State:	ZIP:
	Country:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown
	Phone:		Date of birth:
	Class code wages reported:		W2 Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No
	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:		Occupation:
	Hours worked per week: <input type="checkbox"/> Steady <input type="checkbox"/> Variable		Employment status: <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?		Social Security # or Federal ID#:	
Comments on hours/days worked:		Fed ID Type:	
Avg. weekly value of board (lodging, meals, etc.) received in addition to wages:		Date hired:	
Avg. weekly value of gratuities (tips, etc.) received:		Injury date:	
<b>A C C I D E N T I F I C A T I O N</b>	Place of accident/exposure (address):		City:
	State:	ZIP:	County:
	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		Country:
	Date last worked:	Date employer notified:	Injury reported to:
	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:		
	How injury or illness occurred:		
<b>W A G E S U R E</b>	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
	If the accident was caused by any person or business other than the injured worker, co-worker, or the employer, 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
			List other workers' names:
Witnesses to the accident: (name & phone):			
<b>M E D I C A L P R O V I D E 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 R E S E N T I N G</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
	Comments:		

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