

Iowa Division of Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS (FROI)

Jurisdiction Code \_\_\_\_\_

Jurisdiction Claim Number \_\_\_\_\_

<b>CLAIM ADMIN</b>	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:		
<b>EMPLOYER</b>	Employer Name:		Employer FEIN:		Insured Report Number:	
	Physical Address, City, State, & Postal Code:		Mailing Address, City, State, & Postal Code:		Industry Code:	
	Nature of Business:		Employer Contact Name and Business Phone Number:		Employer Type Code: <input type="checkbox"/> Employer (E) <input type="checkbox"/> Lessor (L)	
				Insured Location Number:		Employer UI Number:
<b>POLICY</b>	Insured Name (parent company if different than employer):		Insured FEIN:		Insured Postal Code:	
					Policy/Contract Number:	
				Coverage Effective Date:		Self Insurance License/ Certificate Number:
				Coverage Expiration Date:		
<b>EMPLOYEE</b>	Employee Name (First, Middle, Last, & Suffix):		Date of Birth:		Gender: <input type="checkbox"/> Transgender (T) <input type="checkbox"/> Male (M) <input type="checkbox"/> Non-Binary (X) <input type="checkbox"/> Female (F) <input type="checkbox"/> Unknown (U)	
	Mailing Address, City, State, & Postal Code:		Date of Hire:		Tax Filing Status (check one): <input type="checkbox"/> Single (A) <input type="checkbox"/> Married/Filing Joint (C) <input type="checkbox"/> Single/Head of Household (B) <input type="checkbox"/> Married/Filing Separate (D)	
	Email:		State of Hire:		Educational Level (grade completed): _____ [GED = 12]	
	Phone Number (include area code):		Employment Status (check one): <input type="checkbox"/> Piece Worker <input type="checkbox"/> Volunteer <input type="checkbox"/> Seasonal <input type="checkbox"/> Apprenticeship/Full-Time <input type="checkbox"/> Apprenticeship/Part-Time <input type="checkbox"/> Regular Employee/Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Other		Employee ID Number (check one): ID # _____ <input type="checkbox"/> Social Security Number <input type="checkbox"/> Employment VISA Number <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/> Employee ID Assigned by Jurisdiction	
	Occupation Description:				Marital Status: (check one) <input type="checkbox"/> Unmarried/Single/Divorced (U) <input type="checkbox"/> Married (M) <input type="checkbox"/> Separated (S)	
	NCCI Classification Code:		Department Where Regularly Worked:		Employee's Authorization to Release the Following: Medical Records <input type="checkbox"/> yes <input type="checkbox"/> no Social Security Number <input type="checkbox"/> yes <input type="checkbox"/> no	
<b>WAGE</b>	Average Wage \$ _____ (check one):		Salary Continued In Lieu of Compensation: <input type="checkbox"/> yes <input type="checkbox"/> no		Employee Number of Dependents: _____	
	<input type="checkbox"/> hourly <input type="checkbox"/> daily <input type="checkbox"/> semi-monthly <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> annual <input type="checkbox"/> weekly		Full Wages Paid for Date of Injury: <input type="checkbox"/> yes <input type="checkbox"/> no		Employee Number of Exemptions: _____ (check one)	
	Number of Days Regularly Worked Per Week: _____		Discontinued Fringe Benefits: \$ _____		<input type="checkbox"/> Entitled <input type="checkbox"/> Withholding	
<b>ACCIDENT/INJURY</b>	_____ 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):			
	Accident Premises Code: <input type="checkbox"/> Employer (E) <input type="checkbox"/> Other (X) <input type="checkbox"/> Lessee (L) <input type="checkbox"/> 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:					
	Accident Location Narrative (if no street address):		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 Site County/Parish:		Witness Name & Business Phone Number:				
<b>MEDICAL</b>	Initial Treatment Code (check one): <input type="checkbox"/> no medical treatment (0) <input type="checkbox"/> minor/on-site treatment (1) <input type="checkbox"/> clinic/hospital visit (2) <input type="checkbox"/> emergency care (3) <input type="checkbox"/> hospitalization > 24 hours (4) <input type="checkbox"/> 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](http://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](http://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](http://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](http://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](http://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](http://www.osha.gov/recordkeeping)

For more information on these and other OSHA requirements, go to: [www.iowaosha.gov](http://www.iowaosha.gov)