IA-1 WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
Roman Catholic Bishop of Louisville, A Corporation Sole
3940 Poplar Level Road
Louisville, KY 40213-1463

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

SIC CODE **EMPLOYER FEIN**

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #:

PHONE#:

CARRIER/CLAIMS ADMINISTRATOR

CARRIER(NAME, ADDRESS & PHONE NO)
ClearPath Mutual
200 EXECUTIVE PARK
LOUISVILLE, KY 40207-4202

(502)894-8484

POLICY PERIOD

CHECK IF APPROPRIATE
SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)
ClearPath Mutual
200 EXECUTIVE PARK
LOUISVILLE, KY 40207-4202
(800)367-5372
Fax (502)894-0066

CARRIER FEIN 61-0447247 **POLICY/SELF-INSURED NUMBER** **1147** ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (FIRST, MI, LAST)
X

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE OF HIRE

STATE OF HIRE

ADDRESS (INCL ZIP)
X

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
X

OF DEPENDEN

NCCI CLASS CODE

RATE
X PER HOUR

___DAY ___MONTH ___WEEK ___OTHER

 # DAYS WORKED
Hour

FULL PAY FOR DAY OF INJURY __YES ___NO

DID SALARY CONTINUE __YES ___NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE

LAST WORK DATE

EMPLOYER NOTIFIE

DATE DISABILITY

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?
___YES ___ NO

TYPE OF INJURY/ILLS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
X

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
X

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 RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ___YES ___NO

WERE THEY USED? ___YES ___NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL(NAME & ADDRESS)

INITIAL TREATMENT
0 NO MEDICAL TREATMENT
1 MINOR BY EMPLOYER
2 MINOR CLINIC/HOSP
3 EMERGENCY CARE
4 HOSPITALIZED > 24 HOURS
5 FUTURE MAJOR MEDICAL
LOST TIME ANTICIPATED

WITNESS (NAME & PHONE #)

NOTIFIED BY

DATE PREPARED

PREPARER'S NAME & TITLE

FAX PHONE NUMBER