EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT.
FATALITIES AND SERIOUS INJURIES MUST BE REPORTED WITHIN 24 HOURS.

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An employer must on this form notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, arising out of and in the course of employment.
ARIZONA REVISED STATUTES 23-908 & 23-1061

FOR CARRIER USE ONLY

DOC TYPE: **IR101**

MAIL *ORIGINAL* TO:

Summit
P.O. BOX 25160
SCOTTSDALE, ARIZONA 85255-0102
1-888-690-2020
FAX 1-480-505-0405

FOR OSHA PURPOSES ONLY

OSHA CASE NO.

RECORDABLE INJURY

NON-RECORDABLE INJURY

EMPLOYER'S NAME
OFFICE ADDRESS

EMPLOYEE 1. LAST NAME	FIRST NAME	M.I.
2. SOCIAL SECURITY NUMBER	3. BIRTHDATE	
4. HOME ADDRESS (NUMBER & STREET/MAILING)		APT. #
CITY	STATE	ZIP CODE
5. (AREA CODE) TELEPHONE		
6 SEX. ☐ M ☐ F	7. MARITAL STATUS SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐	

EMPLOYER	8. EMPLOYER'S NAME	9. POLICY NUMBER	10. NATURE OF BUSINESS MANUFACTURING, ETC.)	
11. OFFICE ADDRESS (NUMBER & STREET)	CITY	STATE	ZIP CODE	12. TELEPHONE
ACCIDENT	13. DATE OF INJURY OR ILLNESS	14. TIME OF EVENT ☐ A.M. ☐ P.M.	15. TIME EMPLOYEE BEGAN WORK ☐ A.M. ☐ P.M.	16. DATE EMPLOYER NOTIFIED OF INJURY
17. LAST DAY OF WORK AFTER INJURY	18. DATE OF RETURN TO WORK	19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED		
20. CLASS CODE ON PAYROLL REPORT	21. EMPLOYEE'S ASSIGNED DEPARTMENT	22. DEPARTMENT NUMBER	23. DID INJURY OCCUR ON EMPLOYER PREMISES? ☐ YES ☐ NO	
24. ADDRESS OR LOCATION OF ACCIDENT	CITY	COUNTY	STATE	ZIP CODE

25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn,

26. PART OF BODY INJURED	Side Injured RT ☐ LT ☐	27. FATAL ☐ YES ☐ NO	28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH
29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO	NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL		ADDRESS (STREET, CITY, STATE & ZIP CODE)
30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ YES ☐ NO	IF HOSPITALIZED, HOSPITAL NAME		ADDRESS (STREET, CITY, STATE & ZIP CODE)

31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON

CAUSE OF ACCIDENT

32. WHAT HAPPENED? Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

33. **WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*

34. **WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA	36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ☐ YES ☐ NO	37. HOURS PER DAY EMPLOYEE WORKED FROM A.M. P.M. THRU A.M. P.M.	38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ☐ YES ☐ NO	39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY
IMPORTANT	IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47	40. DATE OF LAST HIRE	41. WAS WORKER PAID FOR DAY OF INJURY? ☐ YES ☐ NO IF YES, $	42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ☐ YES ☐ NO
43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR	44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE HOUR DAY WEEK MONTH $ PER ☐ ☐ ☐ ☐	45. IS EMPLOYEE FURNISHED ☐ LODGING ☐ BOARD ☐ BOTH	VALUE $	
46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)			47. DOES EMPLOYEE CLAIM DEPENDENTS? ☐ YES ☐ NO	
IMPORTANT	IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55	48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR	49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK	
50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEEDING INJURY FROM THRU $			51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $	
52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY	53. WAGE BEFORE INCREASE $	54. WAGE AFTER INCREASE $	55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $	
AUTHORIZED SIGNATURE	DATE	AUTHORIZED SIGNATURE	TITLE	

NOTE TO EMPLOYER: 1. Mail one copy to Summit within 10 days.
2. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

• The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.