

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP) City of Mammelle 550 Edgewood Drive Suite 590 Mammelle, AR 72113		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG CASE #	REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
INDUSTRY CODE		EMPLOYER FEIN		INSURED REPORT NUMBER
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
				PHONE #
CARRIER/CLAIMS ADMINISTRATOR				
CARRIER (NAME, ADDRESS, & PHONE #)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)	
MUNICIPAL LEAGUE WORKERS' COMPENSATION TRUST P.O. BOX 37 NORTH LITTLE ROCK, ARKANSAS 72115 501-374-3484		TO		
		CHECK IF APPROPRIATE		
		<input type="checkbox"/> SELF INSURANCE		
CARRIER FEIN	POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN	
EMPLOYEE/WAGE				
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED
ADDRESS (INCL ZIP)		SEX	MARITAL STATUS	OCCUPATION/JOB TITLE
		M MALE F FEMALE U UNKNOWN	U UNMARRIED M MARRIED S SEPARATED K UNKNOWN	EMPLOYMENT STATUS
PHONE		# OF DEPENDENTS	NCCI CLASS CODE	
RATE PER:	DAY WEEK	MONTH OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?
				YES NO YES NO
OCCURRENCE/TREATMENT				
TIME EMPLOYEE BEGAN WORK	AM PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE () CANNOT BE DETERMINED	AM PM
CONTACT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		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		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? WERE THEY USED?		YES NO YES NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFF SITE TREATMENT (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
OTHER				
WITNESSES (NAME & PHONE #)				
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE		PHONE NUMBER

AWCC Form 1
(Employer's First Report of Injury or Illness)

Ark. Code Ann. § 11-9-529 allows employers 10 days to report injuries. Those involving either more than 7 days of lost time or indemnity payments require **Form 1**. Also, a Form 1 is required for all controversies including a medical-only case. Self-insured employers file **Form 1** with the AWCC; other employers send it to their insurance representatives.

Employers do **NOT** fill in the shaded areas.

On **Form 1**, employers/carriers must:

1. In the **Occurrence Section** list the date the employer first knew of the injury. The 10 days to report begin either on the date of disability or the date the employer was notified, whichever date is later.
2. Give the name of the carrier. An insurance agency or third party administrator should be listed in the **Preparer's Section**. A carrier can pre-print its name and address in the **Carrier Section** to help clients properly report.
3. Specify the carrier Federal Employer Identification Number (FEIN) in the **Carrier Section**.
4. Type or print in ink. An illegible, incomplete **Form 1** will be returned.

Neglect of **Form 1**: Late employee benefits, exposing employers to fines.

Lack of **Form 1**: Delays in insurance investigation.

General inquiries on Form 1 can be answered by the AWCC Support Services Division. Questions on a specific Form 1 may be directed to the Research and Statistics Section, which processes the accident reports. (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under ... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

(Revised 1-1-2001)