ACORD Workers Compensation –First Report of Injury or Illness

Employer (Name & Address INCL Zip)	Broker (Name, Address & Phone No)	Policy Period
University of Arizona c/o Risk Management Services Dept. PO Box 210300 Tucson, AZ 85721-0300	Marsh USA, Inc 3131 East Camelback Road, Suite 400 Phoenix, AZ 85016	Nov 4, 2011-Nov 4, 2014
	Policy/Self-Insured Number PLAN NO. 01SP585 POLICY NO. PHFD 37255920	

Employer's Contact Person and Number	Broker's Contact Name & NO.	Employer's Location Address (if different)	Location #:
Belen Aranda (520) 621-3626	Andre Hartman 602-337-6308	UNIVERSITY OF ARIZONA	Phone #:

Employee/Wage

Name (Last, First, Middle)	Date of Birth	Social Security Number LEAVE BLANK - will get later	Date Hired	State of Hire
Address (INCL ZIP)	Gender ☐ Male ☐ Female ☐ Unknown	Martial Status ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown	Occupation/Job Title Employment Status	
Phone	# of Dependants		NCCI Class Code	

Rate	☐ Day	☐ Month	Average Weekly Wages	# Days Worked/Week	Full Pay for Day of Injury?	☐ Yes	☐ No
Per:	☐ Week	☐ Other			Did Salary Continued	☐ Yes	☐ No

OCCURRENCE/TREATMENT

Time Employee began work	☐ AM ☐ PM	Date of Injury/Illness	Time of Occurrence	☐ AM ☐ PM	Last Work Date	Date Employer Notified	Date Disability Began

Contact Number/Phone Number	Type of Injury/Illness	Part of Body Affected

Did Injury/Illness Exposure Occur on Employer's Premises? ☐ Yes or ☐ No

Department Or Location Where Accident or Illness Exposure Occurred COUNTRY INFO HERE	All Equipment, Materials, or Chemicals Employee was Using when accident or illness 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/Illness occurred. Describe the Sequence of Events and include any objects or Substances that directly injured the employee or made the employee ill.

Date Returned 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
		☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor Clinic/HOSP ☐ Emergency Care ☐ Hospitalized > 24 Hours ☐ Future Major Medical/Lost time Anticipated

Date Broker Notified	Date Prepared	Preparer's Name & Title	Phone Number