

ACORD Workers Compensation –First Report of Injury or Illness

Employer (Name & Address INCL Zip) University of Arizona c/o Risk Management Services Dept. PO Box 210300 Tucson, AZ 85721-0300		Broker (Name, Address & Phone No) Marsh USA, Inc 3131 East Camelback Road, Suite 400 Phoenix, AZ 85016	Policy Period Nov 4, 2011-Nov 4, 2014
Employer's Contact Person and Number Belen Aranda (520) 621-3626		Broker's Contact Name & NO. Andre Hartman 602-337-6308	Policy/Self-Insured Number PLAN NO. 01SP585 POLICY NO. PHFD 37255920
Employer's Location Address (if different) UNIVERSITY OF ARIZONA		Location #:	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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Marital Status <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		Occupation/Job Title	
Phone		# of Dependants				Employment Status	
Rate		<input type="checkbox"/> Day	<input type="checkbox"/> Month	Average Weekly Wages	# Days Worked/Week	Full Pay for Day of Injury?	
Per:		<input type="checkbox"/> Week	<input type="checkbox"/> Other			<input type="checkbox"/> Yes	<input type="checkbox"/> No
						Did Salary Continued	<input type="checkbox"/> Yes <input type="checkbox"/> No

OCCURRENCE/TREATMENT

Time Employee began work	<input type="checkbox"/> AM <input type="checkbox"/> PM	Date of Injury/Illness	Time of Occurrence	<input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> Yes or <input type="checkbox"/> 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				<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Were they used?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician/Health Care Provider (Name & Address)			Hospital (Name & Address)			Initial Treatment	
						<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor Clinic/HOSP <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/> Future Major Medical/Lost time Anticipated	
Date Broker Notified	Date Prepared	Preparer's Name & Title				Phone Number	