First Report of Injury or Illness (FROI)

Submit by one of these methods: Mail to State Insurance Fund, PO Box 83720, Boise, ID 83720-0044,
upload as an attachment at www.idahosif.org, email as an attachment to reportclaim@idahosif.org, or fax to 208-332-8160

Every work injury that requires medical services other than first aid treatment must be reported within TEN days after the employer has knowledge of the injury. Filing this form is not an admission of liability. This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made.

EMPLOYER

Submission type: ☐ New Claim ☐ Revised Claim Claim number (if revised):		Date prepared:
Employer's name: Northwest Youth Corps		Entity Type: ☐ Sole Proprietor ■ Corporation ☐ LLC ☐ Partnership ☐ Public ☐ Other
Address: 2621 Augusta St.		
City: Eugene	State: OR ZIP: 97403	
Country: USA		Is injured worker a Corporate Officer, Partner, LLC member or Sole Proprietor? ☐ Yes ■ No
Employer's location address: Same		
City: Same	State: Same ZIP: Same	If a Sole Proprietor or LLC, is the injured worker a household member? ☐ Yes ■ No
Country: Same	Policy #: 581951 FEIN:	
Phone: (541) 349-5055	Email: jessicaj@nwyouthcorps.org	Organization code: 93-0818160

EMPLOYEE

Last name:	Suffix:	State where hired: Idaho
First name:	MI:	Occupation: Intern
Address:		Employment status: Seasonal
City:	State: ZIP:	Social Security # or Federal ID#:
Country:	Sex: ☐ Female ☐ Male ☐ Unknown	Fed ID Type: Select one...
Phone:	Date of birth:	Date hired:
Class code wages reported: 8864-000	W2 Employee: ■ Yes ☐ No	Injury date:
Regular job/dept.: Internship Department	Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown	

WAGES

Wage rate: per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Other… explain:	
Hours worked per week: 40.00 ☐ Steady ■ Variable	Days worked per week: 5.00 ☐ Steady ■ Variable
Full pay for the day of injury: ☐ Yes ☐ No If no, how many hours paid for the day of injury?	Did salary continue? ☐ Yes ☐ No
Comments on hours/days worked: Schedules vary depending on field conditions and agency needs, but hours/ week remain the same.	
Avg. weekly value of board (lodging, meals, etc.) received in addition to wages: $0.00	Avg. weekly value of gratuities (tips, etc.) received: $0.00

ACCIDENT OR EXPOSURE

Place of accident/exposure (address):			City:
State:	ZIP:	County:	Country:
Did injury/illness occur on the employer's premises? ☐ Yes ■ No	Time of injury: ☐ AM ☐ PM		Time employee began work: ☐ AM ☐ PM
Date last worked:	Date employer notified:	Injury reported to:	
Date returned to work:	Date disability began:	If fatal, date of death:	
Part(s) of body affected:	Side of body:		Body part injured before: ☐ Yes ☐ No
	Injury type (strain, cut, etc):		
Equipment, materials, or chemicals employee was using upon occurrence:			
How injury or illness occurred:			
Was accident caused by the failure of a machine or product? ☐ Yes ☐ No			Was safety equipment provided? ■ Yes ☐ No
If the accident was caused by any person or business other than the injured worker, co-worker, or the employer, please identify:			Was it used? ■ Yes ☐ No
			Were other workers also injured? ☐ Yes ☐ No List other workers' names:
Witnesses to the accident: (name & phone):			

MED

Medical Provider name & address:	☐ No medical treatment ☐ Minor by employer ☐ Minor - clinic/hospital ☐ Emergency Care ☐ Hospitalized overnight
	Anticipated major medical/time loss: ☐ Yes ☐ No

PREPARER

Name and title: Jessice Johnson - HR Officer	Role: ■ Employer ☐ Injured worker ☐ Insurance Agent ☐ Attorney ☐ Medical Provider	
Phone: (541) 654-4712	Email: jessicaj@nwyouthcorps.org	Prefer contact by: ■ Phone ■ Email
Comments:		

As the employer's representative, SIF will submit the FROI to the Industrial Commission. Keep a copy for your records.