WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)
The Cottages
1079 S. Ancona Ave. Suite 110
Eagle, ID 83616
Att: Jamie Wilson

Carrier/Administrator Claim Number | Report Purpose Code

Jurisdiction | Jurisdiction Claim No.

Insured Report No.

Employer's Location Address (if different) | Location No.

NAICS Code | Employer FEIN | Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)

Policy Period
To
☐ Check if self insured

Claims Admin (Name, Address & Phone Number)

Carrier FEIN | Policy Number or Self-Insured Number: COWC713005 | Administrator FEIN

Agent Name & Code Number

Employee

Legal Name (Last, First, Middle) | Birth Date | Social Security Number | Date Hired | State of Hire

Address (Incl. Zip)

Sex: ☐ Male ☐ Female ☐ Unknown

Marital Status: ☐ Unmarried/ Single/Div. ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

Phone

No. of Dependents

NCCI Class Code

Wage Rate $ | ☐ Day ☐ Week ☐ Month ☐ Other

Days Worked/WK
Hrs Worked per Day

Full Pay for Date of Injury? ☐ Yes ☐ No

Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work | ☐ AM ☐ PM

Date of Injury or Illness

Time Occurred | ☐ AM ☐ PM

Last Work Date | Date Employer Notified | Date Disability Began

Employer Contact Name/Phone Number
Jamie Wilson 208-475-1805

Type of Illness/Injury | Part of Body Affected

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

Type of Illness/Injury Code | Part of Body Affected Code

Department or location where accident or illness exposure occurred

All Equipment, Materials, or Chemicals Employee Using upon Occurrence

Specific Activity Employee Engaged in at Time of Occurrence

Work Process the Employee Was Engaged in at Time of Occurrence

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 Returned to Work | If Fatal, Date of Death

Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No

Were they used? ☐ Yes ☐ No

Treatment

Physician/Health Care Provider (Name & Address)

Hospital (Name & Address)

Initial Treatment
0 ☐ No Medical Treatment
1 ☐ Minor: By Employer
2 ☐ Minor Clinic/Hosp
3 ☐ Emergency Care
4 ☐ Hospitalized – 24 hr.
5 ☐ Anticipated Major Med/Lost Time

Other

Signature of Injured Employee, or Signature on File, Date

Witness to Accident (Name & Phone Number)

Date Administrator Notified | Date Prepared | Preparer's Name & Title | Preparer's Phone Number

Filing this report 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. Idaho Industrial Commission, P.O. Box 83720, Boise, ID 83720-0041 IC Form IA-1 (08/2013)

Berkshire Hathaway
HOMESTATE COMPANIES

EMPLOYEE'S ACCIDENT REPORT

To be completed by the injured worker

Employee name	
Employer name	

Date of accident	
Time of accident	
Time you began work on day of accident	
Location of accident *(specify if off-site address)*	

How did the injury occur? What job duties were you performing? Please describe in your own words.

What part(s) of your body was injured (indicating right and/or left)?

Have you sought any medical treatment for these injuries? If so, specify where and when.

Have you ever injured this part of your body before (yes or no)? If so, please describe how and when the previous injury(s) occurred.

What witnesses were present when the accident occurred? Please provide names if applicable.

Who did you report the injury to? When was the injury reported? Please provide name(s) and job title(s).

What did you do after the accident occurred?

The above report is true and correct:

SIGNATURE:	**DATE FORM COMPLETED:**

Berkshire Hathaway
HOMESTATE COMPANIES

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (800) 661-6029 • FAX: (415) 675-5469

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Employee Name: _____ **Date of Injury:** _____
Employer Name: _____ **Date of Birth:** _____

I hereby authorize the divisions of Berkshire Hathaway Homestate Companies, their representative or bearer, to review, inspect, copy, and/or photograph any and all of the following documents:

1. Any and all medical records, including but not limited to office and hospital records, laboratory results, diagnostic reports and films, psychiatric records, medical correspondences, doctor's and nurse's notes, and medical histories relevant to my workers' compensation claim. I also hereby give permission to Berkshire Hathaway Homestate Company representatives to contact the attending physicians involved in the treatment of all related conditions.

2. All employment and human resource information including but not limited to: hiring and employment records, payroll and income statements, documentation related to this or any other relevant injury and any other information pertinent to providing benefits and services necessary for the completion of this claim.

The released information is required for the following reasons:

1. To provide for adequate preparation, investigation, evaluation, review, and discovery of a claim for workers' compensation benefits. Specifically, to determine the causation and the nature and extent of any possible pre-existing, concurrent or aggravating medical conditions with potential medical, legal, or factual implications in the this work-related injury or injuries.

2. To provide the treating physician, consultant or evaluator with medical information necessary to provide you with the best possible medical care and medical advice.

3. To facilitate recovery of all benefits paid toward your workers' compensation claim from any third party responsible for this injury.

4. To ensure that you are accurately compensated for any amount of lost wages, time or resources while undergoing evaluation, treatment and recovery for this injury.

5. To obtain any information necessary to appropriately determine further actions as a result of the injury or condition and to prevent further issues for you and other employees.

This consent and authorization is effective immediately, and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate on conclusion of the claim without express revocation.

A copy or fax is as valid as the original.

_____
_____
_____
(Names, addresses, and phone numbers of providers)

I have read this authorization and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

Signed: _____ Date: _____

Berkshire Hathaway
HOMESTATE COMPANIES

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (800) 661-6029 • FAX: (415) 675-5469

MEDICAL HISTORY REQUEST

Employee Name: _____ **Date of Injury:** _____
Employer Name: _____ **Completion Date:** _____

Please complete this form by providing your medical history for the past 5 years. This will help ensure that we are able to provide all of your medical records to your current treating physician for you to receive the proper care for your work injury.

Thank you for your cooperation.

Past Injuries, Disabilities, or Other Medical Conditions

Hospitalizations

HOSPITAL NAME, ADDRESS AND PHONE	DATES ADMITTED

Treating Physicians or Groups

DOCTOR OR GROUP NAME, ADDRESS AND PHONE	DATES OF TREATMENT

Berkshire Hathaway HOMESTATE COMPANIES

SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT

Employee name	
Employer name	

Date of accident		
Time of accident		
Date accident reported		
Did the employee report the accident immediately?	YES ☐	NO ☐
Location of accident *(specify if off-site address)*		

How did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were reported as injured?

Has the employee sought any medical treatment for these injuries? If so, specify where and when.

What witnesses were present when the accident occurred (including self)?

Do you have any reason to question the legitimacy of the accident? If so, please explain:

Indicate working conditions present that led to accident (please check all that apply):

- ☐ Unused/unavailable lifting equipment
- ☐ Unused/unavailable PPE (gloves, hardhat, goggles, etc.)
- ☐ Unused/unavailable sharps container
- ☐ Unguarded or improperly guarded equipment
- ☐ Electrical exposure
- ☐ Obstructed view
- ☐ Lack of training
- ☐ Defective tools or equipment
- ☐ Wet/slippery floor
- ☐ Poor housekeeping
- ☐ Interaction with co-worker
- ☐ Interaction with patient or resident
- ☐ Interaction with customer
- ☐ Chemical exposure
- ☐ Motor vehicle accident
- ☐ Other: _____

What changes could be made to eliminate or reduce the hazard(s) identified above?

The above report is true and correct:

Prepared by:	**Title:**	**Date prepared:**

Berkshire Hathaway HOMESTATE COMPANIES

WITNESS' REPORT/STATEMENT OF EMPLOYEE ACCIDENT

Employee name	
Witness name & phone number	
Witness Address	

Date of accident	
Time of accident	
Location of accident *(specify if off-site address)*	

Did you witness the above-reported accident? If so, how did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were injured? Describe the type of injury (strain, bruise, etc.)

What did the injured employee say at the time of injury? Did the injured employee complain of pain at the time of injury? If they complained of pain, please specify the body part(s).

What did the employee do after the accident occurred?

Were any other witnesses present at the time of the accident? If so, please list them below.

The above report is true and correct:

Signature of witness:	**Date signed:**

NOTE: Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties.