EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT.
FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

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An employer must on this form notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, arising out of and in the course of employment.

ARIZONA REVISED STATUTES 23-908 & 23-1061

MAIL *ORIGINAL* TO:

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

MAIL *COPY* TO:

STATE COMPENSATION FUND
P.O. BOX 33069
PHOENIX, ARIZONA 85067-3069
1-800-231-1363
FAX 1-800-356-4867

FOR CARRIER USE ONLY

DOC TYPE: **IR101**

IMPORTANT >> TO BE COMPLETED BY EMPLOYER

OSHA CASE NO.

8. EMPLOYER'S NAME

S. E. INGRAM & COMPANY, INC.

9. OFFICE ADDRESS

2151 E. BROADWAY RD #206
TEMPE AZ 85282

FOR LEASED WORKERS TO:

EMPLOYEE 1. LAST NAME | FIRST NAME | M.I.

2. SOCIAL SECURITY NUMBER | 3. BIRTHDATE

4. HOME ADDRESS (NUMBER & STREET/MAILING) | APT. #

CITY | STATE | ZIP CODE

5. MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW/ER | 6. SEX ☐ M ☐ F

7. (AREA CODE) TELEPHONE

10. (AREA CODE) TELEPHONE: 480-967-6466 | 11. POLICY NO. | 12. NATURE OF BUSINESS (MFG, ETC.) | 7A. HIRE LOCATION CITY | STATE

ACCIDENT 13. DATE OF INJURY | 14. HOUR OF INJURY AM PM | 15. DATE EMPLOYER NOTIFIED OF INJURY | 16. LAST DAY OF WORK AFTER INJURY | 17. DATE OF RETURN TO WORK

18. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED | 19. CLASS CODE ON PAYROL REPORT | 20. EMPLOYEE'S ASSIGNED DEPT. | DEPT. SUB CODE | DEPT. NO.

22. ADDRESS OR LOCATION OF ACCIDENT | CITY | COUNTY | STATE | ZIP CODE

23. ON EMPLOYER PREMISES? ☐ YES ☐ NO | 24. NATURE OF INJURY (SCRATCH, CUT, BRUISE, ETC.) | FATAL? ☐ YES ☐ NO | 25. PART OF BODY INJURED | SIDE INJURED RT LF BOTH

26. ATTENDING PHYSICIAN, IF KNOWN (NAME) | ADDRESS (STREET, CITY, STATE & ZIP CODE) | (AREA CODE) TELEPHONE

27. IF HOSPITALIZED, HOSPITAL NAME | ADDRESS (STREET, CITY, STATE & ZIP CODE)

28. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON | 29. WAS WORKER IN YOUR EMPLOY WHEN INJURED ☐ YES ☐ NO

30. CAUSE OF ACCIDENT

31. SPECIFY MACHINE, TOOL, SUBSTANCE, OR OBJECT MOST CLOSELY CONNECTED WITH **ACCIDENT** | 32. WHAT WAS EMPLOYEE DOING WHEN ACCIDENT OCCURRED (LOADING TRUCK, WALKING DOWN STAIRS, ETC.)?

33. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

IMPORTANT WAGE DATA>>>>>>>>>>>>> | 34. DATE OF LAST HIRE | 35. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE $ PER ☐ HR. ☐ DAY ☐ WK. ☐ MO. | 36. WAS EMPLOYEE PAID FOR DATE OF INJURY? ☐ YES ☐ NO IF YES, AMOUNT $

37. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ☒ YES ☐ NO | 38. NUMBER OF DAYS PER WEEK EMPLOYEE USUALLY WORKED ☐ COMPANY USUALLY WORKS ☐ | 39. HOURS PER DAY EMPLOYEE WORKED From AM PM Thru AM PM | 40. DOES EMPLOYEE OWN PART OR ALL OF BUSINESS ☐ YES ☐ NO

41. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR | 42. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ☐ YES ☐ NO | 43. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? OVER HOURS | PER HOUR $

44. NUMBER OF HOURS OF OVERTIME CONSIDERED NORMAL PER WEEK | 45. IS EMPLOYEE FURNISHED ☐ LODGING ☐ BOARD/MEALS ☐ BOTH VALUE $ ☐ PER WK. ☐ PER MO. ☐ PER YR. | 45A. DOES EMPLOYEE CLAIM DEPENDENTS ☐ YES ☐ NO

IMPORTANT >>>>>>>>>> IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY COMPLETE ITEMS 46 THRU 52 | 46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEDING INJURY (EXAMPLE IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7) $

47. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEDING INJURY FROM THRU $ | 48. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $

49. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY | 50. WAGE BEFORE INCREASE $ | 51. WAGE AFTER INCREASE $ | 52. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $

AUTHORIZED SIGNATURE | DATE | AUTHORIZED SIGNATURE | TITLE