EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES

INDUSTRIAL COMMISSION OF ARIZONA P.O. BOX 19070

PHOENIX. ARIZONA 85005-9070

Do not attach this form to email; use USPS or FAX.

MAIL TO CARRIED NAME & ARREGO

FOR	CARRIER	USE	ONLY

FOR OSHA PURPOSES ONLY

WOST BE REPO	RIED WITHIN 24 HC	JUKS.	IVIAIL	. TO: (CARRIE	EK NAME & ADL	(KESS)	OSHA Case	= #.				
Employer must, on this form, notify his insurance carrier of every						RECORDABLE INJURY			RY			
injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise our of or in the course of employment.							NONEDER					
	anse our of or in the coul ED STATUTES 23-91	1997 BUSING BUSIN BUSINSS BUSINSS AND STREET					NON-RECORDABLE INJURY					
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EMPLOYEE	E 1. LAST NAME				M.I.	2. SOCIAL SE	CIAL SECURITY NUMBER * 3. BIRTH DATE			3. BIRTH DATE		
4 HOME ADDDESS (A	UMDED & OTDEET)		OUTV		OT LES		718 0005	-	5 TELEBUIONE			
4. HOME ADDRESS (N	UMBER & STREET)		CITY		STATE		ZIP CODE	1	5. TELEPHONE			
6 SEV 7 MADITAL STATUS												
6. SEX												
	8. EMPLOYER'S NAME		527-150		Lo policynii	MDED	. 	1 40 NA	TUDE OF BURN	IECC (MANUELCTUDING ETC.)		
EMPLOYER		L SWIM SCHOO	I		9. POLICY NU	WIDER		6987 69429	WIM SCH	NESS (MANUFACTURING, ETC.)		
11. OFFICE ADDRESS		CITY		*******				12. TELEPHON				
MULTIN AND SELECTION OF THE MULTINAS AND AND AND	T RAY ROAD #27			HANDLER		STATE ZIP CODE			SHOUL ACTUAL PRODUCTION AND THE SHOP			
	13. DATE OF INJURY OF	THINESS	14. TIME OF EVE	really.	AZ 8522			(480) 961-7946 16. DATE EMPLOYER NOTIFIED OF INJURY				
ACCIDENT	13. DATE OF INSORT OF	CILLINESS	14. THE OF LYL	Carro Santa			A.M.	P.M.	10. DATE LIVIEL	OTER NOTH IED OF INSORT		
17. LAST DAY OF WO	DV AETED IN ILIDY	18. DATE OF RETU	DN TO WORK		EMPLOYEE'S OCCUP	ATION (IOP TITLE		UN STILLINGS				
Tr. DAST DATION WO	KAI IER INJORI	10. DATE OF RETO	KN 10 WORK	13.	LIMIFLOTEL 3 OCCOR	ATION (JOB TITLE	.) WHEN INSORE					
20. CLASS CODE ON F	PAVDOLL DEPORT	21. EMPLOYEE'S A	SSIGNED DEPAR	PTMENT 22	DEPARTMENT NUME	FD ,	23. DID INJURY (OCCUP ON	EMPLOVED DE	PEMISES2		
20. 02.000002.011	THE COLUMN TO TH	21.12.11.12.01			DELT THE THOME		_					
24. ADDRESS OR LOC	ATION OF ACCIDENT	550		CIT	V .	COUNTY	L YES	LI NO	TATE	ZIP CODE		
24. ADDITEOU ON EOU	ATTON OF ACCIDENT			011	n.g.	0001111				ZII OODE		
25 WHAT WAS THE IN	JUIDY OD ILLNESS2 Tellu	s the part of the hody that	was afferted and b	now it was affected: I	ne more specific than"	nurt ""nain " or sore	" Evamoles: "str	ained hack"	"chemical hum	hand"; "carpal tunnel syndrome."		
20. ************************************	100111-01112011-10110	o are part or are body area.	was an ected and t	iow it was affected, i	oc more specific train	iat, pan, or sore	Examples. Sa	dirica bacit	, chemical barry	nana, capa tame synarone.		
26. PART OF BODY IN	JURED		27. FA	ATAL		28. IF THE	EMPLOYEE DIED	. WHEN DI	D THE DEATH O	OCCUR? DATE OF DEATH		
					YES 🔲 NO							
29. WAS EMPLOYEE 1	REATED IN AN EMERGEN	CY NAME OF PHYS	CICIAN OR OTHER	R HEALTH CARE PE	ROFESSIONAL		ADDRESS (STRE	ET. CITY.	STATE & ZIP CO	ODE)		
ROOM?	77 <u>1</u> 1						<i>h</i> 2					
SO WAS EMBLOVEE H	YES NO		ED, HOSPITAL NA	ME			ADDRESS (STRE	ET CITY	STATE 9 71D CC	DDE)		
AN IN-PATIENT?	OSI TIABLED OF ENGIOTT	A3 II IIOSI ITALIZI	D, HOU HALMA	WIL.			ADDICESS (STILL	L 1, OI 1 1,	JIMIL WEIL OC)DL)		
04 15 74110177 05 01	YES N											
31. IF VALIDITY OF CL	AIM IS DOOBTED, STATE P	REAGON										
CALIDE OF	30 MUAT HADDENEDS	Tall us how the injury occ	irred Evernoles	"When ladder clinne	d on wet floor, worker	ell 20 feet" "Works	ar was enraved wit	h chlorine w	han gaekat hrok	e during replacement"; "Worker		
CAUSE OF ACCIDENT	developed soreness in wris		итец. Ехатріса.	when ladder slippe	d off wet floor, worker	eli 20 leet, Wolke	si was sprayed wit	ii cilioillie w	ricii gasket broki	s daining replacement, wholker		
AGGIDZIKI	t .											
33. WHAT OBJECT OF	SUBSTANCE DIRECTLY H	ARMED THE EMPLOYE	E? Examples: "co	oncrete floor"; "chlor	ine", "radial arm saw."	If this question doe	es not apply to the	incident, lea	ave it blank.			
				the activity, as well a	is the tools, equipment	or material the emp	oloyee was using.	Be specific	. Examples: "cli	mbing a ladder while carrying		
roofing materials"; "spra	ying chlorine from hand spra	yer"; "daily computer key-	entry."									
35. IF ANOTHER PERS	ON NOT IN COMPANY EMP	PLOY CAUSED ACCIDEN	T, GIVE NAME AI	ND ADDRESS								
EMPLOYEE'S	36. WAS WORKER IN YO WHEN INJURED?	OUR EMPLOY 37. H	DURS PER DAY E	EMPLOYEE WORKE	D	38. WAS EMF WHEN INJUR	PLOYEE ON OVE	RTIME	39. NUMBE USUALLY V	R OF DAYS PER WEEK		
WAGE DATA	- V/EO	□ NO FROM	4.3.4	DM TUDO			ES	NO				
A ASSERT CHECKEN AND AND AND AND AND AND AND AND AND AN	IF WORK LOSS IS EXPE	CTED TO EXCEED SEVE	V 40. DATE	P.M. THRU OF LAST HIRE	A.M. P.M. 41. WAS WORKE			42. WAS	EMPLOYEE HIS	COMPANY RED FOR PERMANENT		
IMPORTANT	CALENDAR DAYS, COMP				☐ YES ☐ N			EMPLOY	MENT?	_		
43. NUMBER OF MON	THS EMPLOYMENT	44. GIVE EMPLOYEE'S V	VAGE STATUS A	S APPLICABLE	45. IS EMPLOYEE			0.		YES NO		
AVAILABLE DURING TH		HOU	R DAY W	EEK MONTH	- IS LIMITED TEL	p <u>—</u>	32 <u>—</u> 3		YM	-9		
AC ACTUAL ODGE	A PAULAGO OF THE COLUMN	\$ PER			LODGING	BOARD	□ вотн	5	\$	(Secondality)		
46. AUTUAL GROSS E (EXAMPLE: IF INJURE	ARNINGS OF EMPLOYEE F D APRIL 8, GIVE EARNINGS	FOR THE 30 CALENDAR [S FROM MARCH 9 THRU	JAYS PRECEEDI! APRIL 7)	NG INJURY		47. D0	DES EMPLOYEE	CLAIM DEF	PENDENTS?	YES NO		
The second secon	a priitaria de las liste ling de ministra materiales et a contactor contactor sociales de les est											
IMPORTANT	IF EMPLOYEE IS PAID O OR MONTHLY SALARY, (S EXTRA PAY FOR O	VERTIME, WHAT IS	S BASIS OF		BER OF HOURS PER WEEK	OVERTIME CONSIDERED		
MITORIAN			LAND			Ē	PER HOUR	- Almonia	and the same of the same			
50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEEDING INJURY 51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH												
¢ 1						DAY PRIOR TO INJURY						
FROM THRU 52. DATE OF LAST WAGE INCREASE IF 53. WAGE BEFORE INCREASE 54. WAGE AFTER IN					The state of the s	FROM THRU						
WITHIN 12 MONTHS PI	RIOR TO INJURY	22		2								
AUTHORIZED		\$ I AUTHODI	ZED SIGNATURE	\$. 8)	Til I	TITLE				
AUTHURIZED	PAIL	AUTHURI	FFD DIGNATORE					TITLE				

NOTE TO EMPLOYER:

- 1. 2. 3.
- Mail one copy to the Industrial Commission within 10 days.
 Mail one copy to your insurance carrier within 10 days.
 Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the
 Federal Occupational Safety and Health Act of 1970.

SIGNATURE

^{*} The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.