Vork	ers' Compensation – FIRST REPORT OF INJUR	Y OR ILLNESS	Jı	urisdiction (Code_		Jurisdictio	n Claim Numb	er		
7	Claim Administrator Name: RAS Companies Mailing Address, City State & Postal Code: P.O. Box 89310 Sioux Falls, SD 57109-9310			Claim Representative Business Phone Number:			ne Insur	Insurer Name (if different than claim administrator)			
CLAIM ADMIN				Claim Administrator Claim Number		Insurer FEIN:					
				Claim Administrator FEIN:			Clain	Claim Type Code:			
	Employer Name:			Employer FEIN:			Insure	Insured Report Number:		Employer	Type Code
EMPLOYER	Physical Address, City, State & Postal Code:			Mailing Address, C		City, State& Postal Code	Indus	Industry Code: 866101 Insured Location Number:		X Employer (E) Lessor (L Employer UI Number:	
EMPL	Nature of Business:			Employer Contact Name & Business Pho			s Phone Nu	one Number:			
	Insured Name (parent company if different than employer):	Insured FEIN:	Insured Postal	Policy/Contract Number: Co			Coverage	overage Effective Date: Self Insurance License/			
POLICY	Roman Catholic Diocese of Des Moines 4206802 55		Code:	WC020-0053338- 2024A-IA		07/01/	2024 Expiration Date:	Certificate Num			
	Employee Name (First, Middle, Last & Suffix):		Date of Birth:	<u> </u>		Gender	00/30/			tus (chock one)	
	Employee Name (First, Middle, Last & Julia).		Sate of Sitting			Male (M)		<u>Tax Filing Status</u> (check one) Single (A)			
	Mailing Address, City, State & Postal Code:		Date of Hire:		_	Female (F)		Single/HeadHousehold (B) Married/Filing Joint (C)			
								Married/FilingSeparate(D)			
			Employment St	tatus (check	one)	Employee ID Numb	er (check or	check one)		Marital	Status:
EMPLOYEE			Piece Work	er		ID#			Unmarried (U		(U)
EMF	Phone Number (include area code):		Volunteer			Social Security Num		nber		Married (M)	
			Seasonal	bio /5 Tio		Employment VISA Number		r	Separated		(S)
	Occupation Description:	Apprenticeship/Full-Time Apprenticeship/Part-Time			Passport Number Green Card				loyee's Aut	horization to	
	Manual Classification Code:	Regular Employee/Full-T		ime	ne				al Records	yes no	
	Department Where Regularly Worked:		Part-Time			p.is/ss is / issig		-		Security #	yes no
			Other								
	Average Wage \$(check one)		Salary Continued in Lieu of Compensation: yes no			no	Employee Number of Dependents:				
WAGE	hourly daily semi-monthly monthly		Full Wages Pa	id for Date of	for Date of Injury: yes no		no	Employee Number of Exemptions: (check one)			
>	bi-weekly annually weekly							Entitled Withholding			
	Number of Days Regularly Worked Per Week:	Discontinued Fringe Benefits: \$									
	Date of Injury Date Employer Had Knowledge of the Injury		Describe the nature of the injury. (ex. amputation, burn, cut, fracture):								
	Date Claim Administrator Had Knowledge of the Injury		Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):								
	Initial Date Last Worked										
URY	Initial Return to Work Date (if applicable) Employee Date of Death (if applicable)										
ACCIDENT / INJURY			Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):								
	Time of Injury Time Employee Began Work										
	Pre-Existing Disability Code: Yes										
	No Unknown	Name the object	or substan	ce tha	at directly injured the e	employee. (ex. knife, floor,	acid, o	il):		
	Accident Premises Code: Employer (E										

Other (X)

	Accident Site Organization Name: Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring)								
		Indicate if activity was part of normal duties:							
	Accident Site Street, City, State & Postal Code:								
	Accident Location Narrative (if no street address):								
	Accident Site County/Parish:		Witness Name & Business Phone Number:						
MEDICAL	Initial Treatment Code: (check one)		Initial Medical Provider Name:	Managed Care Organization Name or ID Number:					
	no medical treatment (0)								
	minor/on-site treatment (1)								
	Clinic/hospital visit (2)		Initial Medical Provider Physical Address, City, State,	ICD Primary Diagnostic Code (if known):					
	Emergency care (3)								
	Hospitalization .24 hours (4)								
	Future Medical treatment/lost time anticipated (5)								
	Preparer's Name & Title	Pre	parer's Company Name:	Phone Number:		Date:			

IAIABC FORM 1.2 (12/98)