

# Diocese of Des Moines: Completing the First Report of Injury Form to Report an Employee Injury

To report an employee workplace injury or illness, you need to complete the First Report of Injury (FROI) form, which is available online here: Workers' Compensation | Diocese of Des Moines.

Download the form by clicking the download icon or the save icon can then save your progress as you gather information.

Completed forms should be sent to Jill Noordhoek at <a href="mailto:jill.noordhoek@assuredpartners.com">jill.noordhoek@assuredpartners.com</a> hours of notice of the injury or illness.

The different sections of the form are addressed below.

Fields outlined in red in the screenshots below *MUST* be completed before submitting the form. They include:

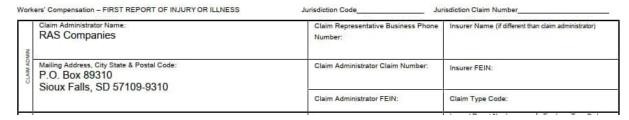
- Employer Name
- Employer Contact Name & Business Phone Number
- Employee Name and ID Number (typically a social security number)
- Date of Injury
- Something in any of the Injury section fields
- Treatment under the Medical section

<sup>&</sup>lt;sup>1</sup> For convenience, a video walkthrough of these instructions can be found online here: <u>Diocese of Des Moines FROI Demo</u>.

Fields outlined in blue also should be completed if the information is readily available.

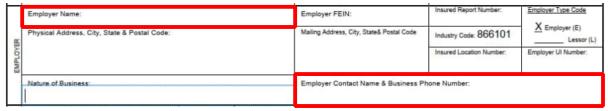
- Please include as much of this information as you can if this information is not readily available, please include the information available and submit the form.
- Submitting the information as soon as possible is more important than completing every field.

## **CARRIER ADMIN**



You do not need to complete any information in the top section of the form (Jurisdiction Codes/Numbers or the **CARRIER ADMIN** section). These fields are for the insurance carrier, so you can disregard them.

## **EMPLOYER**



Employer Name should be the specific location (ex: parish or school) name, not just "Diocese of Des Moines."

#### **POLICY**

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POLICY	Insured Name (purent company it offerent than employer): Roman Catholic Diocese of Des Moines	4206802	Code:	Policy/Contract Number: WC020-0053338- 2024A-IA	07/01/2024	Self Insurance License/ Certificate Number:
		55			06/30/2025	

This section is already completed by the Diocese. If you are reusing a form and the date of injury is after the Coverage Expiration Date listed in this section, then please download the current form from the Diocese website (Workers' Compensation | Diocese of Des Moines).

## **EMPLOYEE**

EMPLOYEE	Employee Name (First, Middle, Last & Suffix):	Date of Birth:	Gender	iender <u>Tax Filing Status</u> (check one)	
	Mailing Address, City, State & Postal Code:	Male (M)  Date of Hire: Female (F		Single (A)  Single/HeadHousehold (B)  Married/Filing Joint (C)  Married/FilingSeparate(D)	
	Phone Number (include area code):	Employment Status (check one)  Piece Worker  Volunteer  Seasonal	Employee ID Numb ID# Social Security Employment V	Number	Marital Status:  Unmarried (U)  Married (M)  Separated (S)
	Occupation Description:  Manual Classification Code:	Apprenticeship/Full-Time Apprenticeship/Fart-Time Regular Employee/Full-Time	Passport Numb Green Card Employee ID As	ber Assigned by Jurisdiction	Employee's Authorization to Release the Following: Medical Records  yes no Social Security # yes no
	Department Where Regularly Worked:	Part-Time Other			

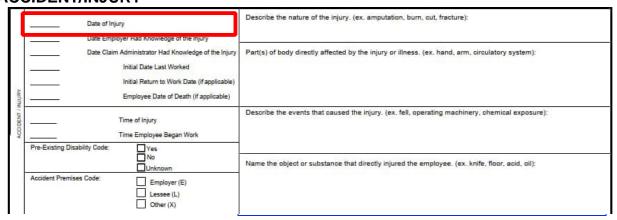
Employee ID Number is typically the injured employee's social security number.

## **WAGE**



This entire section is especially important if you expect the injured worker is likely to miss more than three (3) days of work.

## **ACCIDENT/INJURY**



Note: This section continues onto the second page of the form.

# **ACCIDENT/INJURY** – continued

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:			

Accident Site and subsequent details also are important if the injury occurred somewhere other than the location already described in the "Employer" section.

# **MEDICAL**



If you know that treatment was provided, but you do not have any details about the treatment, please indicate that treatment was provided. If you do not know, please list "Unknown."

## **PREPARER**



This form should be completed by the employer, NOT the injured worker.