THIS MUST BE COMPLETED AND SUBMITTED WITH EMPLOYEE'S FIRST REPORT OF INJURY- PLEASE COMPLETE ALL QUESTIONS ON THIS FORM!

VOLUNTEER FIRE DEPARTMENT/AMBULANCE SERVICE

1. Name of Volunteer Fire Dept/Ambulance Service ____

   Address____

   Contact Person___________________________________Phone Number ______________________

2. Was volunteer firefighter/ambulance personnel working in capacity of volunteer at time of accident?
____

3. Does volunteer firefighter/ambulance personnel receive any pay other than per run pay? _______If yes, how much?_________

4. Does volunteer firefighter/ambulance service carry any other policies?
   ____

   Workers' Compensation _____________________Disability_____________________________________

   If so, name of company __________________________Policy benefit____________________________

VOLUNTEER FIREFIGHTER/AMBULANCE PERSONNEL

1. Name of Volunteer Firefighter/Ambulance Personnel
   ____

   Address____

   Telephone____

2. Name of Volunteer's Regular Employer (Not Fire Dept. or Ambulance Service)_____________________

   Nature of Business____

3. Volunteer's Occupation (Not Fire Dept. or Ambulance Service)
   ____

4. Name of Supervisor: __________________________Phone Number______________________________

5. Number of Hours Worked Per Day ___________________Per Week______________________________

6. Number of Days Worked Per Week ____

7. Wages:___________ Per Hour____________ or Per Day ___________or Per Week__________________

8. If paid on other than a time basis (piece rate, salary, commission, etc.) enter actual average weekly earnings: $_________________________per week.

Workers' Compensation
Personnel Cabinet
State Office Building
501 High Street, 3rd Floor
Frankfort, Kentucky 40601