

**THIS MUST BE COMPLETED AND MAILED WITH EMPLOYEE'S FIRST REPORT OF INJURY SUPPLEMENT TO IA-1 EMPLOYER'S FIRST REPORT OF INJURY**

**VOLUNTEER FIRE DEPARTMENT**

1. Name of Volunteer Fire Department \_\_\_\_\_  
Address \_\_\_\_\_  
Contact Person \_\_\_\_\_ Phone Number \_\_\_\_\_
2. Was firefighter working in capacity of volunteer at time of accident? \_\_\_\_\_
3. Does firefighter personnel receive any pay other than per run pay? \_\_\_\_\_  
If yes, how much? \_\_\_\_\_
4. Does department carry any other policies? \_\_\_\_\_  
Workers' Compensation \_\_\_\_\_ Disability \_\_\_\_\_  
If so, name of company \_\_\_\_\_ Policy benefit \_\_\_\_\_

**VOLUNTEER FIREFIGHTERS**

1. Name of Volunteer Firefighter \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_
2. Name of Volunteer's Regular Employer (not Fire Department) \_\_\_\_\_  
Nature of Business \_\_\_\_\_
3. Volunteer's Occupation (not Fire Department) \_\_\_\_\_
4. Supervisor's Name \_\_\_\_\_ 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, 3<sup>rd</sup> Floor  
Frankfort, KY 40601  
502-564-6846**

**PLEASE ANSWER ALL QUESTIONS OF THIS FORM!**