

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

VOLUNTEER AMBULANCE SERVICE

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

VOLUNTEER AMBULANCE PERSONNEL

1. Name of Volunteer Ambulance Personnel _____
Address _____
Telephone _____
2. Name of Volunteer's Regular Employer (not Ambulance Service) _____
Nature of Business _____
3. Volunteer's Occupation (not Ambulance Service) _____
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, 3rd Floor
Frankfort, KY 40601
502-564-6846**

PLEASE ANSWER ALL QUESTIONS OF THIS FORM!