Form 122

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

(Filing this form is not an admission of liability for the claim.)

GENERAL

Employer (Name & Address Including Zip)

Carrier/Administrator Claim Number

OSHA Log Number

Report Purpose Code

Jurisdiction

Jurisdiction Claim Number

Insured Report Number

Employer's Location Address (If Different)

Location Number

Phone Number

Industry Code

Employer FEIN

CARRIER/CLAIMS ADMINISTRATOR

Carrier (Name, Address & Phone Number)

Policy Period

To

Check If Appropriate

Self-Insurance

Claims Administrator (Name, Address & Phone Number)

Carrier FEIN

Policy/Self-Insured Number

Administrator FEIN

Agent Name and Code Number

EMPLOYEE/WAGE

Name (Last, First, Middle) Address (Incl. Zip)

Date of Birth

Social Security Number

Date Hired

State of Hire

Sex: Male / Female / Unknown

Marital Status: Unmarried/single/Divorced / Married / Separated / Unknown

Occupation / Job Title

Employment Status

NCCI Class Code

Claimant may need an Interpreter: Yes No

Language

Phone

Number of Dependents

WAGE

Rate Per: Day Month Week Other

Number of Days Worked/Week

Full Pay For Day of Injury? Yes No

Did Salary Continue? Yes No

OCCURRENCE/TREATMENT

Time Employee Began Work AM PM

Date of Injury/Illness

Time of Occurrence AM PM

Last Work Date

Date Employer Notified

Date Disability Began

Contact Name/Phone Number

Type of Injury/Illness

Part of Body Affected

Did Injury/Illness Exposure Occur on Employer's Premises? Yes No

Type of Injury/Illness Code

Part of Body Affected Code

Department Or Location Where Accident or Illness Exposure Occurred

All Equipment, Materials, or Chemicals Employee Was Using When Accident Or Illness Exposure Occurred

Specific Activity The Employee Was Engaged In When The Accident Or Illness Exposure Occurred

Work Process The Employee Was Engaged In When Accident Or Illness Exposure Occurred

Cause Of Injury Code

How Injury or Illness / Abnormal Health Condition Occurred, Describe the Sequence of Events and Include Objects or Substances that Directly Injured The Employee or Made The Employee Ill

Date Return(ed) to Work

If Fatal, Give Date of Death

Were Safeguards Or Safety Equipment Provided? Yes No

Were They Used? Yes No

Physician/Health Care Provider (Name & Address)

Hospital (Name & Address)

Initial Treatment
- No Medical Treatment
- Minor: By Employer
- Minor: Clinic/Hospital
- Emergency Care
- Hospitalized – 24 hrs
- Future Major Medical/Lost Time Anticipated

OTHER

Witnesses (Name & Phone Number)

Date Administrator Notified

Date Prepared

Preparer's Name & Title

Phone Number

Official Form 122 *Revised 03/17*

State of Utah • Labor Commission • Division of Industrial Accidents

160 East 300 South • P.O. Box 146610 • Salt Lake City, UT 84114-6610 • Telephone: (801) 530-6800

FAX: (801) 530-6804 • Toll Free: (800) 530-5090 • www.laborcommission.utah.gov

For your protection Utah Law requires notice that worker's compensation fraud is a crime. Please see back of this form for the full fraud statement.

Form 100

INJURED WORKERS' RIGHTS AND RESPONSIBILITIES

This form shall be provided to the injured worker per §34A-2-407(6) Utah Code Annotated.

RIGHTS:

- **MEDICAL EXPENSES**: You are entitled to have all reasonable medical expenses paid that are as a result of a work-related injury or illness. You may also be eligible for reimbursement for travel to and from approved medical care.
- **COMPENSATION BENEFITS**: You may be entitled to 66-2/3% of your wages up to 100% of the state average weekly wage if the claim is found to be compensable and a physician states you are totally unable to work. No compensation benefits are paid in the first three days unless the disability prevents you from working for more than a total of 14 days. If your work injury or illness prevents you from earning your full wage while you are recovering and working with restrictions, you may be entitled to partial compensation. If you have sustained a permanent impairment due to an industrial injury or disease, you are entitled to disability compensation based on an impairment rating as determined by a physician. If you are permanently and totally disabled from working due to an industrial injury, you may need to apply for a hearing at the Labor Commission to determine if benefits are due.
- **DEPENDENT BENEFITS**: In the case of death of an employee resulting from a work-related injury, workers' compensation shall pay some funeral and burial expenses. In addition, the deceased worker's spouse, dependent children, and other dependents may be entitled to monthly payments.
- **REEMPLOYMENT ASSISTANCE**: You may be eligible for reemployment assistance if you are unable to return to work due to an industrial injury. Contact the insurance adjuster or the Utah State Office of Rehabilitation for further information at 801-887-9500 or www.usor.utah.gov.

RESPONSIBILITIES:

- **EMPLOYER'S PHYSICIAN**: If your employer has a company physician or designated clinic for industrial accidents, you must see the company physician first or you may be obligated to pay for the difference in medical costs. After you have been seen by your employer's physician, you have the right to change the treating physician once throughout the duration of your claim.
- **MEDICAL RECORDS**: You shall comply with rules adopted by the Labor Commission regarding disclosure of your medical records which are relevant to the industrial accident or illness claim, otherwise benefits could be denied.
- **COOPERATION**: Promptly provide information requested by the insurance adjuster and cooperate with the investigation of your claim. If a claim is denied and you disagree with the denial reason, you may file an application for hearing and an Administrative Law Judge will issue a decision on your claim.
- **MEDICAL COOPERATION**: You must cooperate with your employer or the insurance adjuster by following prescribed medical treatments/evaluations/visits as to return to work as quickly as possible.
- **CONCERNS**: Contact the insurance adjuster if problems arise concerning your industrial accident claim regarding medical treatment, payment of medical bills, compensation benefits, or work restrictions. If you have any additional questions regarding your rights and responsibilities throughout the duration of the claim process, feel free to contact the Utah Labor Commission, Division of Industrial Accidents.

FRAUD STATEMENT – "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

This form must accompany the establishing first report of injury.

UTAH LABOR COMMISSION – Division of Industrial Accidents
160 EAST 300 SOUTH – 3rd FLOOR, PO BOX 146610
SALT LAKE CITY, UT 84114-6610
Phone: (801) 530-6800 • Toll Free: (800)530-5090 • Email: IACCD@utah.gov

If you want an Employee's Guide to Workers' Compensation or have questions, contact the Labor Commission or visit the website at: www.laborcommission.utah.gov.

Rev: Mar 2017

EMPLOYEE'S REPORT OF ACCIDENT

Employee's name ______________________________ Age _______ Sex _______

Employer____________________Department__________________

Job position/title ________________________ Social Security number ________________

Shift hours _______________ Days off ____________ Supervisors name ______________

Date and time of accident ____________________ Location __________________________

Task being performed when accident occurred ______________________________________

Date and time accident reported ____________________ To whom? _________________

Name(s) of witness(es) ____

____

Describe how the accident occurred ____

____

____

____

What part of the body was injured? ____

Describe the injuries in detail ____

____

____

Date, time you first sought medical attention _____________________________________

Name of doctor and/or hospital ____

Could anything be done to prevent accidents of this type? If so what? _________________