Form 122

For your protection Utah Law requires notice that worker's compensation fraud is a crime. Please see next page for the full fraud statement.

WORKER'S COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS
STATE OF UTAH-THE LABOR COMMISSION - DIVISION OF INDUSTRIAL ACCIDENTS
160 E 300 S, P.O. BOX 146610
SALT LAKE CITY, UTAH 84114-6610

GENERAL

EMPLOYER (Name & Address Incl. Zip)

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA CASE/FILE # | **REPORT PURPOSE CODE**

JURISDICTION | **JURISDICTION CLAIM NUMBER**

INSURED REPORT NUMBER

EMPLOYERS LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

SIC CODE | EMPLOYER FEIN | PHONE #

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE #)

UTAH SCHOOL BOARDS RISK MANAGEMENT MUTUAL INS. ASSOCIATION
860 East 9085 South Sandy, UT 84094
(801) 569-3632

POLICY PERIOD
TO

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE #)

UTAH SCHOOL BOARDS RISK MANAGEMENT
MUTUAL INSURANCE ASSOCIAATION
860 East 9085 South
Sandy, UT 84094 (801) 569-3632

CARRIER FEIN: 87-0529711 | POLICY/SELF-INSURED NUMBER | **ADMINISTRATOR FEIN**: 87-0529711

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN

MARITAL STATUS: ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | **NCCI CLASS CODE**

WAGE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER: | # OF DAYS WORKED/WEEK | FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO | DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

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

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL | **CAUSE OF INJURY CODE**

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO | WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR: BY EMPLOYER
- ☐ MINOR CLINIC/HOSP
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED>24 HRS
- ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESS (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

FRAUD - "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 the state prison."

EMPLOYEE INFORMATION

- **INJURY/ILLNESS REPORT** A report of your injury/occupational illness must be made with your employer. If a report of injury is not filed with your employer of the Labor Commission within 180 days of the date of your injury/illness you may lose the right to ever file a claim for worker's compensation benefits for that injury or illness.

- **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 not be eligible for workers compensation benefits. After you have been seen by your employer's physician you have the right to choose one treating physician.

- **MEDICAL COOPERATION** You must cooperate with your employer or the insurance carrier in following prescribed medical treatment in order to return to work as quickly as possible.

- **TRAVEL REIMBURSEMENT** You may be eligible for travel reimbursement to and from approved medical care. You will need to keep records. Contact your insurance carrier regarding travel expenses.

- **REEMPLOYMENT ASSISTANCE** You may be eligible for reemployment assistance if you are unable to return to work due to an industrial injury. Contact your insurance carrier or the Labor Commission for further information.

- **MEDICAL EXPENSES** You are entitled to have all reasonable medical expenses paid that were a result of the injury or illness.

- **COMPENSATION BENEFITS** You are entitled to 66-2/3 of your wages up to 100% of the state average weekly wage (on the date of your injury) after 3 days from the date of your injury, if a physician states your are totally unable to work. If you were off over 14 days due to your injury, compensation is then payable from the first day. You are then entitled to workers compensation benefits until you reach maximum medical improvement from the industrial injury/illness.

If you have sustained a permanent impairment due to the industrial injury or illness you are entitled to benefits based on the impairment rating as determined by a physician.

If you are permanently totally disabled from working due to the industrial injury you may need to apply at the Labor Commission for a hearing to determine if benefits are due.

- **ADDITIONAL ASSISTANCE** If you are unable to work due to an industrial injury and meet the program's requirements, you may be eligible for other assistance. Agencies you may wish to contact:

    Human Services for food stamps, cash assistance, or medical assistance.
    Social Security for total disability benefits.

- **UNEMPLOYMENT BENEFITS** If you are able to work but have been terminated from your job you need to apply at the nearest Job Service Office within 90 days of the termination or worker's compensation payments.

Contact your insurance carrier if problems occur during your injury regarding payment of medical bills or compensation payments. If you need to know who your employer's insurance carrier is, either ask your employer or contact the Labor Commission.

For further information or assistance contact:
Labor Commission of Utah
Division of Industrial Accidents
160 East 300 South - 3rd Floor
P.O. Box 146610
Salt Lake City, Utah 84114-6610
(801) 530-6800

THIS IS AN IMPORTANT DOCUMENT TO MAINTAIN FOR YOUR RECORDS