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)
- SIC CODE
- EMPLOYER FEIN
- **CARRIER/ADMINISTRATOR CLAIM NUMBER**
- OSHA CASE/FILE #
- **REPORT PURPOSE CODE**
- **JURISDICTION**
- **JURISDICTION CLAIM NUMBER**
- INSURED REPORT NUMBER
- EMPLOYERS LOCATION ADDRESS (IF DIFFERENT)
- LOCATION #
- PHONE #

CARRIER / CLAIMS ADMIN

- CARRIER (NAME, ADDRESS & PHONE #)

  Worker Compensation Fund
  P.O. Box 57929
  Salt Lake City, UT 84157-0929
  Telephone: (801) 288-8010 Toll Free # 1-800-446-2667

- POLICY PERIOD ____ TO ____
- CHECK IF APPROPRIATE
  - ☐ SELF INSURANCE
- CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE #)
- **CARRIER FEIN**
- POLICY/SELF-INSURED NUMBER
- **ADMINISTRATOR FEIN**
- 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 state prison."

INSTRUCTIONS TO EMPLOYER

The Employer's First Report of Injury or Illness must be submitted to the Labor Commission, Division of Industrial Accidents, per Sections §34A-2-407 and §34A-3-108, Utah Code Annotated (U.C.A.), 1997. Each employer shall file the report within **seven days** after the occurrence of a fatality, injury, or occupational disease, or after the employer's first knowledge of the occurrence, or the employee's notification of the same, which results in medical treatment, loss of consciousness, loss of work, restriction of work, or transfer to another job. Each employer shall file a subsequent report with the commission of any previously reported injury or occupational disease that later resulted in death. Also, for your information, Section §34A-6-301(3)(b)(ii) states that each employer shall, within 12 hours of occurrence, notify the Division of Occupational Safety and Health, at (801) 530-6901 or (800) 530-5090, of any: work related fatality; disabling, serious, or significant injury; or occupational disease incident. A serious injury includes: amputation, fractures of major bones (both simple and compound), and hospitalization for medical treatment.

* All information requested on this form is of vital importance. Please answer **all** items in detail in order to avoid additional correspondence or the return of this report for completion.

* Please provide **WAGE** information. This information is needed by the insurance company for paying the correct amount of a claim.

* The injury report on file with the Labor Commission, Division of Industrial Accidents, is private information and is only released to parties to the claim.

* Please make sure the **EMPLOYER NAME** is correct, as well as your **UI#** (Unemployment Insurance Number). The employer's name should be the same as reported to The Department of Workforce Services and as it appears on your WORKERS' COMPENSATION insurance policy.

* **The Labor Commission** is to receive the **original** of this report, **Worker's Compensation Insurance Carrier** gets the **second** copy, the **employee** gets the **third** copy, and the **employer** gets the **fourth** and should maintain a copy of this report.

* Failure to file this report with the Labor Commission or failure to provide the employee with a copy of the report, is a Class C misdemeanor and can also result in a citation and a civil penalty for each violation as per §34A-2-407(7), §34-A-3-108(7), §34A-6-302, and §34A-6-307, U.C.A.

* If you dispute the validity of this claim you need to contact your insurance carrier.

* **Reminder:** Inform your injured employee of his/her rights and obligations (as outlined on the back of the employee's copy) of Utah's Workers' Compensation Act.

For additional Information please contact:

State of Utah - Labor Commission
Division of Industrial Accidents
160 East 300 South, 3rd Floor
P.O. Box 146610
Salt Lake City, Utah 84114-6610
(801) 530-6800 (800) 530-5090