

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						
	SIC CODE		EMPLOYER FEIN		EMPLOYERS LOCATION ADDRESS (IF DIFFERENT)		LOCATION #		
						PHONE #			
CLAIMS ADMINISTRATOR	CARRIER (NAME, ADDRESS & PHONE #)		POLICY PERIOD		CLAIMS ADMINISTRATOR (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		TO						
	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	MARITAL STATUS		OCCUPATION/JOB TITLE			
			MALE FEMALE UNKNOWN	UNMARRIED SINGLE/DIVORCED MARRIED SEPARATED UNKNOWN		EMPLOYMENT STATUS			
	PHONE		# OF DEPENDENTS			NCCI CLASS CODE			
WAGE	RATE	PER:	DAY	MONTH	# OF DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	YES	NO	
			WEEK	OTHER:		DID SALARY CONTINUE?	YES	NO	
OC-CUR-REN-C-E	TIME EMPLOYEE BEGAN WORK	AM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN	
		PM			PM				
	CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED		
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?			TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE		
	YES						NO		
	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 you 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