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

Industry Code | Employer FEIN | Phone Number

CARRIER

CLAIMS ADMIN

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

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

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 IllnessExposure 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 TheEmployee 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

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

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 insurance carrier, per Sections §34A-2-407 and §34A-3-10B, R612-200-1 Utah Code Annotated (U.C.A.) 1997. Each employer shall file the report within seven days after the occurrence, or the employee's notification of the same, which results in medical treatment by a physician except first-aid R612-100-2, 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 8 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**. Do not enter data in the shaded areas.**

* The box titled "OSHA Log Number" must be filled in with the employer assigned Case Number from OSHA's new 300 Injury Log. The Case Number needs to reflect the year of the injury – for example, your first injury in 2002 should reflect the first injury and the year 00/02 with the next injury being 00202, etc.

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

* The electronic 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 **FEIN #** (Federal Tax ID 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 **Worker's Compensation Insurance Carrier** gets an original copy, the **employee** gets a **second** copy, and the employer gets a **third** copy and should maintain a copy of this report. The insurance carrier will send the Labor Commission an electronic copy of the injury report.

* Failure to file this report with the insurance carrier 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), R612-200-1, §34-a-30108(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, and you must still file the "Employer's First Report of Injury or Illness" form with them. They will then submit it to the Labor Commission electronically. If the employer has no workers' compensation insurance this form must be submitted to the Labor Commission directly.

* **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

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

Form 100-SP

DERECHOS Y RESPONSABILIDADES DE LOS TRABAJADORES LESIONADOS

Esta declaración se proporcionará al trabajador lesionado por §34A-2-407(6) Código de Utah Anotado.

DERECHOS:

- **GASTOS MÉDICOS**: Usted tiene derecho a que se paguen todos los gastos médicos razonables que sean como resultado de una lesión o enfermedad relacionada con el trabajo. También puede ser elegible para el reembolso por el viaje hacia y desde proveedores médicos aprobados.

- **BENEFICIOS DE LA COMPENSACIÓN**: Usted puede tener derecho a 66-2/3% de su salario hasta el 100% del salario promedio semanal del estado si el reclamo se determina que es compensable y un médico declara que usted es totalmente incapaz de trabajar. No se pagan beneficios de compensación en los primeros tres días a menos que la discapacidad le impida trabajar más de un total de 14 días. Si su lesión laboral o enfermedad le impide ganar su salario completo mientras se está recuperando y trabajando con restricciones, puede tener derecho a una compensación parcial. Si usted ha sufrido una incapacidad permanente debido a una lesión o enfermedad industrial, tiene derecho a una compensación de incapacidad que es basada en una calificación de incapacidad que es determinada por un médico. Si está permanentemente y totalmente incapacitado de trabajar debido a una lesión o enfermedad laboral, tiene que solicitar una audiencia en la Comisión Laboral para determinar si los beneficios son debidos.

- **BENEFICIOS PARA DEPENDIENTES**: En caso de muerte de un empleado como resultado de una lesión relacionada con el trabajo, la compensación para los trabajadores pagará algunos gastos funerarios y del entierro. Además, el esposo/la esposa, los hijos a cargo, y otros dependientes del trabajador fallecido pueden tener derecho a pagos mensuales.

- **ASISTENCIA DE REEMPLAZO**: Usted puede ser elegible para recibir asistencia de reempleo si no puede regresar al trabajo debido a una lesión laboral. Para obtener más información, comuníquese con el ajustador de seguros o con la Oficina de Rehabilitación del Estado de Utah al 801-887-9500 o www.usor.utah.gov.

RESPONSABILIDADES:

- **MÉDICO DEL EMPLEADOR**: Si su empleador tiene un médico de la compañía o una clínica designada para accidentes industriales, es necesario ver al médico de la compañía primero o puede estar obligado a pagar por la diferencia en los gastos médicos. Después de haber sido visto por el médico del empleador, tiene el derecho de cambiar al médico tratante una vez durante la duración de su reclamo.

- **REGISTROS MÉDICOS**: Usted deberá cumplir con las reglas adoptadas por la Comisión Laboral con respecto al descargo de sus registros médicos que sean relevantes al reclamo de accidente o enfermedad industrial, si no los beneficios podrían ser negados.

- **COOPERACIÓN**: Proporcione rápidamente la información solicitada del ajustador de seguros y coopere con la investigación de su reclamo. Si se niega su reclamo y no está de acuerdo con la razón de denegación, puede presentar una solicitud de audiencia y un Juez de Derecho Administrativo hará una decisión sobre su reclamo.

- **COOPERACIÓN MÉDICA**: Usted debe cooperar con su empleador o con el ajustador de seguros en seguir los tratamientos, evaluaciones, y visitas médicas para regresar al trabajo lo más rápido posible.

- **PREOCUPACIONES**: Póngase en contacto con el ajustador de seguros si tiene problemas acerca de su reclamo de accidente industrial con respecto al tratamiento médico, pago de facturas médicas, beneficios de compensación o restricciones de trabajo. Si tiene preguntas adicionales sobre sus derechos y responsabilidades durante el proceso de reclamo, debe comunicarse con la Comisión Laboral de Utah, División de Accidentes Industriales.

DECLARACIÓN DE FRAUDE – "Cualquier persona que a sabiendas presente información falsa o fraudulenta de suscripción de seguros, archivos o causas para presentar una reclamo falso o fraudulento por compensación de incapacidad o beneficios médicos, o presente un informe o facturación falsa o fraudulenta por gastos médicos u otros servicios profesionales es culpable de un crimen y pueden ser sujetos a multas y confinamiento en prisión estatal."

Este formulario debe acompañar el primer informe de enfermedad.

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Si desea una Guía Sobre el Seguro de Compensación Para Los Trabajadores o tiene preguntas, comuníquese con la Comisión Laboral o visite el sitio web en: www.laborcommission.utah.gov. Rev: Mar 2017