Print Form

Form 122

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

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

GENERAL

Employer (Name & Address Include Zip)
Tremonton City Corporation
102 S. Tremont St.
Tremonton, UT 84337

Industry Code:
Employer FEIN: 87-6000288

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: 435-257-9506

CARRIER / CLAIMS ADMIN

CARRIER/CLAIMS ADMINISTRATOR

Carrier (Name, Address & Phone Number)
Travelers 800-227-1538
PO Box 173762
Denver, CO 80217-3762

Policy Period _____ To _____
Check If Appropriate: Self-Insurance ☐

Claims Administrator (Name, Address & Phone Number)
Utah Local Governments Trust
PO Box 173762 800-227-1538
Denver, CO 80217-3762

Carrier FEIN:
Policy/Self-Insured Number: CCSSC 306T3656
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 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

OTHER

Witnesses (Name & Phone Number):
Date Administrator Notified:
Date Prepared:
Preparer's Name & Title:
Phone Number:

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

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-3-10B, 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, 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 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 Labor Commission is to receive an original of this report, **Worker's Compensation Insurance Carrier** gets a **second copy**, the **employee** gets a **third** copy, and the employer gets a **fourth** copy 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-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, but you must still file the "Employer's First Report of Injury or Illness" form with the Labor Commission.

* **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

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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 or the Labor Commission, Division of Industrial Accidents, within 180 days of the date of your injury/illness, you may lose the right to ever file a claim for workers' 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, Division of Industrial Accidents, for further information.

- **MEDICAL EXPENSES**: You are entitled to have all reasonable medical expenses paid that are 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 (as of 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 have sustained a permanent impairment due to the industrial injury or disease, you are entitled to compensation 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, Division of Industrial Accidents, 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:

  - ☐ Department of Workforce Services for food stamps, cash assistance, medical assistance, or employment 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 Department of Workforce Services employment office within 90 calendar days after you are released from full-time work by your doctor.

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

THIS IS AN IMPORTANT DOCUMENT TO MAINTAIN FOR YOUR RECORDS

Notes: