FORM 122

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.

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 LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER / CLAIMS ADMIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE#)	POLICY PERIOD ... TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO)
	CHECK IF APPROPRIATE ☐ SELF-INSURANCE	

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

AGENT NAME AND CODE NUMBER

EMPLOYEE / WAGE

EMPLOYEE/WAGE

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

ADDRESS (INCL ZIP)	SEX	MARITAL STATUS	OCCUPATION / JOB TITLE
	M MALE F FEMALE U UNKNOWN	U UNMARRIED SINGLE/DIVORCE M MARRIED S SEPARATED K UNKNOWN	EMPLOYMENT STATUS
PHONE	# OF DEPENDENTS		NCCI CLASS CODE

RATE PER:	☐ DAY ☐ WEEK	☐ MONTH ☐ OTHER	# 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

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAMES & ADDRESS)	HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HRS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

OTHER

WITNESSES (NAME & PHONE #)

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

FORM 1A-1(r1-1-02) **SEE BACK FOR IMPORTANT INFORMATION**

© IAIABC 2002

Labor Commission W.C. Insurance Carrier Employee Employer's File