WORKERS' COMPENSATION NOTICE

Employer:_____
has complied with the provisions of the Workers' Compensation Act (§34A-2-101, Utah Code Annotated), the Utah Occupational Disease Act (§34A-3-101, Utah Code Annotated), and the rules of the Labor Commission by insuring the liability to pay the compensation and other benefits provided by said Acts through:

Insurance Company: _____

Policy Number: _____

Address for the above insurance company: _____

Telephone number: _____

☐ Check here if the employer has been authorized by the Division of Industrial Accidents to self-insure and directly pay workers' compensation benefits.

WORKERS' COMPENSATION

Workers' Compensation is insurance which pays medical expenses and helps offset lost wages for employees with work-related injuries or illnesses. If you have an on-the-job injury or occupational disease, it may pay for: hospital and medical bills, time lost from work, permanent loss of body function, prosthetic devices, and burial and dependent benefits in case of death.

HOW TO REPORT AN ACCIDENT

1. Report the injury, no matter how slight, immediately to your supervisor. You may lose your rights if your injury is not reported within 180 days of the injury or work-related illness.
2. Ask your employer where you should go for treatment. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.
3. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a physician's initial report form. A copy of the report is given to you and copies of the report are sent to the insurance company and the Labor Commission within seven (7) days of your doctor visit.
4. Your employer shall fill out the employer's first report of injury form. A copy of this report is sent to the insurance company within seven (7) days of the accident. The insurance company will report the injury to the Labor Commission.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation benefits for the company.
2. Ask your employer to report the accident to the insurance company and give you the claim number.
3. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the employer's report, the physician's report, and may ask you to fill out a request for compensation. Cooperate with the adjuster's investigation of the injury.
4. Ask your doctor to send medical reports to the insurance company, including the work status statement.

REHABILITATION

If you cannot return to work, you may be eligible for a rehabilitation program. Contact the insurance company listed above or the Utah State Office of Rehabilitation.

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."

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 www.laborcommission.utah.gov

If you want copy of an *Employee's Guide to Workers' Compensation* booklet or have questions, contact the Labor Commission or go to the webpage at www.laborcommission.utah.gov.

Note: This notice must be posted and kept continuously in public and conspicuous places in the office, shop or place of business of the employer as per §34A-2-204 and §34A-2-104.5, Utah Code Annotated.

Rev 10/2019

AVISO DE COMPENSACIÓN PARA LOS TRABAJADORES

La Empresa: _____

Ha cumplido con las disposiciones de la Ley de Compensación para los Trabajadores (§34A-2-101, Código de Utah Anatado), la Ley de Enfermedades Ocupacionales de Utah (§34A-3-101, Código de Utah Anatado), y las reglas de la Comisión Laboral por asegurando la obligación de pagar compensactión y otros beneficios preveidos por las Leyes y teniendo cobertura con:

Compañía de Seguros: _____

Numero de Póliza: _____

Dirección de la compañía de seguros: _____

Numero de teléfono: _____

☐ Marque aquí si la División de Accidentes Industriales ha autorizado el empleador a tener el auto-seguro y pagar los beneficios de compensación directamente al trabajador.

COMPENSACIÓN PARA LOS TRABAJADORES

Compensación para los trabajadores es un seguro que paga los gastos médicos y ayuda a compensar los salarios perdidos de los empleados con lesiones o enfermedades relacionadas con el trabajo. Si usted tiene una lesión en el trabajo o una enfermedad occupasional, puede pagar: facturas hospitalarias y médicas, pérdida de tiempo del trabajo, pérdida permanente de la función corporal, dispositivos protésicos y servicios funerarios y beneficios para dependientes en caso de muerte.

COMO REPORTAR UN ACCIDENTE

1. Informe inmediatamente a su supervisor de la lesión. Usted puede perder sus derechos si no reporte su lesión o enfermedad relacionada con el trabajo dentro de 180 días.
2. Pregunte a su empleador dónde debe ir para recibir tratamiento. Si su empleador tiene un clínico designado, vaya allí de inmediato para recibir tratamiento. Si no tiene un clínico designado, vaya a un médico de su elección.
3. Informe al doctor CÓMO, CUÁNDO y DÓNDE ocurrió el accidente. El médico llenará el formulario de informe inicial del médico. Usted debe recibir una copia del informe y copias se envían a la compañía de seguros y a la Comisión Laboral dentro de siete (7) días de su visita al médico.
4. Su empleador llenará el formulario de informe inicial del empleador. Usted debe recibir una copia del informe y una copia se envía a la compañía de seguros dentro de siete (7) días. La compañía de seguros es responsable a reportar a la Comisión Laboral.

COMO EMPEZAR COMPENSACIÓN

1. Pregunte a su empleador qué compañía de seguros pagará los beneficios de compensación para los trabajadores.
2. Pídale a su empleador que reporte el accidente a la compañía de seguros y que le dé el número de reclamo.
3. Llame a la compañía de seguros y pídales que inicien sus beneficios de compensación para trabajadores. La compañía de seguros requerirá el informe del empleador, el informe del médico, y puede pedirle a usted que llene una solicitud de compensación. Cooperar con la investigación del ajustador sobre la lesión.
4. Pídale a su médico que envíe informes médicos a la compañía de seguros, incluyendo la declaración de estado de trabajo.

REHABILITACIÓN

Si no puede regresar al trabajo, puede ser elegible para un programa de rehabilitación. Póngase en contacto con la compañía de seguros mencionada anteriormente o con la Oficina de Rehabilitación del Estado de Utah.

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 una prisión estatal."

UTAH LABOR COMMISSION
Industrial Accidents Division

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Teléfono: (801)-530-6800 Fax: (801)-530-6804 Línea gratuita: (800)-530-5090 www.laborcommission.utah.gov

Si desea una copia del folleto de *la Guía Sobre el Seguro de Compensación Para los Trabajadores* o tiene preguntas, comuníquese con la Comisión Laboral o visite la página web en www.laborcommission.utah.gov.

Nota: Este aviso debe ser publicado y mantenido continuamente en lugares públicos y visibles en la oficina, tienda o lugar de negocios del empleador según §34A-2-204 y §34A-2-104.5, Código de Utah Anatado.

UTAH WORK INJURY REPORTING PROCEDURES

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

Employers First Report of Injury or Illness (Form 122)

This form must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, Employers First Reports of Injury or Illness may be submitted to us online at: www.berkindcomp.com. Online Reporting Instructions are enclosed. Maintain a copy of the Employers First Report of Injury or Illness for your records. Keep a separate file for each workers' compensation claim.

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the Employers First Report of Injury or Illness. If the Employers First Report of Injury or Illness is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

Wage Statement

Wage statements must be completed on claims involving lost time from work. The employee's gross wages for the 52 weeks prior to the date of injury are required. If the employee has not been employed for 52 weeks, then report the available wages. In addition to regular pay, computation of wages may include overtime, tips, and the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee. If there are weeks with no wages, please explain the reason by coding as follows:

V= Vacation I= Illness L= Lay off P= Personal leave O= Other

Please contact our claims department with questions.

Do not delay reporting the Employers First Report of Injury or Illness for completion of the wage statement.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

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 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

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.

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

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

Form 123

Physician's Initial Report of Work Injury or Occupational Disease

INSTRUCTIONS: 1) form to be completed by physician; 2) copy of completed form to be sent to insurance carrier with bill and progress reports; 3) copy of form only sent to injured employee, employee's employer, and Utah Labor Commission.

This report must be filled pursuant to rule R612-100-3 (A), Utah Administrative Code. For your protection Utah law requires notification that any workers' compensation fraudulent claim for disability compensation on medical benefits is a crime and may be subject to fines and prison confinement.

PLEASE PRINT OR TYPE

PHYSICIAN

1. Physician Name
2. Physician Phone Number
3. Treatment Facility
4. Registered Email

Do Not Use This Space
CLAIM NO.
POLICY NO.
Class Code

CARRIER

5. Insurance Company
6. Mailing Address City State Zip

PATIENT

7. Employee's First Name Middle Initial Last Name
8. SS # (or other)
9. DOB (MM/DD/YYYY)
10. Gender
11. Mailing Address City State Zip
12. Employee Telephone Number

EMPLOYER

13. Name of Employer
14. Address City State Zip
15. Employer Telephone Number

HISTORY

16. Date Injured (MM/DD/YYYY) Hour _____ AM ☐ PM ☐
17. Last Date Worked
18. Employee's Statement of Cause of Injury or Illness (In First Person)

EXAMINATION

19. Diagnosis (Written Description as Related to Industrial Claim) w/ ICD Code
20. Is the Condition Requiring Treatment the Result of the Industrial Injury or Exposure Described?
☐ Yes ☐ No Undetermined
21. Claimant Needs Interpreter ☐ Yes ☐ No Language _____ (If Answer is Yes)

COMMENTS

22. Other Comments
23. Date Submitted _____

Official Form 123 **Revised 10/14**
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

Form 307

MEDICAL TREATMENT PROVIDER LIST

PLEASE PRINT OR TYPE

Claimant Name _____ Social Security Number _____
Address _____ Date of Injury _____
_____ Employer _____
Telephone Number _____

"Notification to the Workers' Compensation Claimant"

Per Labor Commission Rule R612-300-10, an injured worker who files a claim for workers' compensation benefits is required, requested, to provide the name and address of medical providers who have provided any medical treatment for up to the past 10 years. This is your notice that any and all of the medical records within the custody of the medical provider that you have listed may be requested by the party named on this form, as authorized by Rule R612-300-10.* The medical provider is required to release the medical records per the rule, in order for the insurance carrier, self-insured employer, or the Labor Commission to make a determination in your case.

*You are required to sign the "Authorization to Release Medical Records" Form 308.

Please list all the medical providers for industrial injuries first.
Please list any other medical providers who have treated you for medical problems within the past _____years (up to 10 years).

_____ _____
_____ _____
_____Zip _____ _____Zip _____
Telephone Number _____ Telephone Number _____

_____ _____
_____ _____
_____Zip _____ _____Zip_____
Telephone Number _____ Telephone Number _____

_____ _____
_____ _____
_____Zip _____ _____Zip _____
Telephone Number _____ Telephone Number _____

_____ _____
_____ _____
_____Zip _____ _____Zip _____
Telephone Number _____ Telephone Number _____

Please attach additional pages, if necessary.

Name of Party Requesting the Medical Records _____
Address _____
Telephone Number _____ Fax _____
Relationship to the Claim _____

*Medical Providers who have treated you related to your reproductive organs or for psychological problems do not have to be listed unless you have made a claim for benefits related to these medical problems.
Failure to return this form to the requester may result in a delay or denial of your claim.

Official Form 307 **Revised 03/15**
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*

WAGE STATEMENT

In order to determine with accuracy, the average weekly wages in accordance with the provisions of the Workmen's Compensation Law, please fill out and return.

This is to certify that I _____ am the _____
(Name of Person Certifying) (Name of Office or Position Held)

of _____ of _____
(Name of Employer) (Number, Street, City, Town)

employer of _____ injured on or about _____, _____
(Name of Injured Person) (Month, Day, Year)

"A" I have examined the payroll of said employer and the following table shows the days worked and the wages earned by said _____ employed as a _____ during the period stated therein.

"B" I have examined the payroll of said employer and find that _____ the injured employee, did not work for said employer a substantial portion of the year before the accident.

The following table shows the days worked and the wages earned by _____ another employee of the same class employed by the same employer who did work a substantial part of such year in the same or similar employment.

Official Position _____ Signed By _____

	WEEK ENDING			Days Worked	Amount Paid Including Overtime		WEEK ENDING			Days Worked	Amount Paid Including Overtime
	Month	Day	Year				Month	Day	Year		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					
			TOTAL PAID						TOTAL PAID		
									TOTAL GROSS		