

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

TO BE COMPLETED BY EMPLOYER WITH ORIGINAL SENT TO INSURANCE CARRIER AND COPY SENT TO INJURED WORKER

INJURED WORKER INFORMATION:

Name:	Phone:
Address:	City: State: Zip:
Social Security Number:	Date of Birth:
Marital Status:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/>
Occupation / Job Title:	Date Hired:
Employment Status:	Number of Dependents:
Wage: Wage Period:	Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/>
Full Pay for Day of Injury: Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of Days Worked per Week:

EMPLOYER INFORMATION:

Business Name:	Phone:
Employer Contact:	Phone:
Mailing Address:	City: State: Zip:
Employment Address:	City: State: Zip:
Employer FEIN:	

INSURANCE INFORMATION:

Carrier:	Phone:
Carrier Address:	City: State: Zip:
Policy / Self-Insured Number:	Policy Period:

OCCURRENCE/TREATMENT:

Date of Injury / Disease:	Time of Injury:	Date Employer Notified:
Nature:	Body Part:	Cause:
Last Day Worked:	Date Disability Began:	Date Returned to Work:
Fatality: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Death:	Date Administrator Notified:
Address of Occurrence:	City:	State: Zip:
Premises: Employer's <input type="checkbox"/> Other <input type="checkbox"/> Description:		
Accident Description:		

Provider Injured Worker Received Care From:

Provider Address :	City:	State:	Zip:
Treating Physician:	Phone:		
Initial Treatment:	No Medical Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinic/Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized- 24 Hours <input type="checkbox"/> Future Major Medical/Lost Time Anticipated <input type="checkbox"/>		
Witnesses: Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes list their names and phone number:		

For your protection, it is required by Utah Law to give notice that workers' compensation fraud is a crime. See next page for full fraud statement.



INSTRUCTIONS TO THE EMPLOYER**PLEASE NOTE:**

The filing of this form does not admit liability or fault. However, failure to file this report with the insurance carrier and provide a copy to the injured worker can result in a citation and civil penalty for each violation as per §34A-2-407(8), U.C.A.

The insurance carrier is to receive the original of this form. The injured worker shall then receive a copy along with their rights and obligations of the Utah's Workers' Compensation Act (Form 100). The employer should keep a copy for their records. The Labor Commission, Division of Industrial Accidents, will receive an electronic copy from the insurance carrier. The electronic copy of this form is private information and only released to parties of the claim.

In order to dispute the validity of the injured worker's claim, contact the insurance carrier or claim administrator for more information.

All fields on this form are required. Please complete this form entirely and do not leave any blank fields. This form will be returned and additional information will be requested if it is not properly completed. If you, the employer, need assistance to complete the form contact your workers' compensation insurance carrier or claims administrator.

Rule R612-200-1(A)(2) Except for injuries treated only by first aid, an employer shall report each employee work injury within 7 days after receiving initial notice of the injury, as follows:

- a. An employer that has obtained workers' compensation insurance shall report the injury to its insurance carrier.*
- b. An employer that has received Division authorization to self-insure shall report the injury to its claims administrator.*
- c. An employer that has failed to obtain worker's compensation coverage shall report the injury by contacting the Division directly.*

3. An employer has notice of a work injury upon the earliest of:

- a. Observation of the injury;*
- b. Verbal or written notice of the injury from any source; or*
- c. Receipt of any other information sufficient to warrant further inquiry by the employer.*

FRAUD WARNING:

Any person who knowingly presents false or fraudulent underwriting information, files, claim for disability compensation, medical benefits, health care fees, or other professional services are of guilty of a crime and may be subject to fines and confinement in state prison.



Form 102

APPLICATION TO CHANGE DOCTORS

Name of Injured Person

Carrier File No. _____

Home Address (street)

Social Security No. _____

City/State/Zip _____ Home Phone Number _____

On _____, 20____, I sustained an injury/occupational disease arising out of and in the course of my employment at _____

Employer Name

Employer Address

City/ State/ Zip

Phone Number

Briefly describe how accident occurred, parts of body injured, and results _____

I have been treated by the following doctors (Give full names and addresses in the order in which they were seen): _____

I asked my present doctor for a referral. Yes____No____Referral was approved. Yes____No____
I would like permission to change from Dr. _____

(Give full name, title [M.D., D.C., etc.], address and zip)

To Dr. _____

(Give full name, title [M.D., D.C., etc.], address and zip)

My reasons for wanting to change are:

MAIL THIS REQUEST TO:

Insurance Carrier/Adjustor _____

Street or Mailing Address _____

City, State, Zip _____

ACTION ON REQUEST

Approved by:_____ Date:___ Denied by:_____ Date:___ Reasons for denial:_____

***Copies of this form approved or denied, must be mailed promptly to the applicant and to the doctor the applicant has requested to be the treating physician. Per R612-300-2, after an injured worker has exercised his or her one-time right to change health care providers, the worker must use this form to request payor approval of any subsequent change of provider.



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

EMPLOYEE'S NOTIFICATION OF INTENT TO LEAVE LOCALITY OR STATE, AND TO CHANGE DOCTOR OR HOSPITAL

This form must accompany Form 043.

NOTICE: Injured employees should contact the insurance carrier prior to making plans to leave the state for medical care. **THE CARRIER MAY NOT BE LIABLE FOR ANY OR ALL OF THE COSTS.** Other states are not bound by our limitations on medical fees and you may have to pay the difference between what is allowed in Utah and what the new physician charges. If you have a question as to who the carrier is, ask your employer.

INCOMPLETE OR UNSIGNED FORMS WILL BE RETURNED. NO ACTION WILL BE TAKEN UNTIL THE ATTENDING PHYSICIAN'S STATEMENT (FORM 043) IS RECEIVED.

Name of Employer

Date of Injury

Street Address of Employer

Insurance Carrier

City, State and Zip of Employer

Employer's Area Code and Telephone #

Name of Employee (Printed)

Utah Street Address of Employee

New Address of Employee

Utah City and Zip Code of Employee

New City, State and Zip Code of Employee

Utah Phone #

SS#

New Area Code and Phone #

I left/intend to leave (circle one) the state on (date)_____. I have/have not (circle one) reported to my last Utah physician_____ for a current examination.

(Physician full name and title)

(Physician's complete address, including zip and office number)

(Please check): The Attending Physician's Statement (Form 043) describing my condition when last examined is attached to this request. (This form will not be processed without accompanying Form 043.)

The treating physician that I have chosen in my new location is:

Dr. _____

Name (including title)

Address, Office #, City, State & Zip

Area Code and Phone Number

Employee's Signature

Receipt acknowledged by: _____ Date: _____

Copies mailed to: _____

Mail completed form to: Utah Labor Commission – Industrial Accidents Division at address below.



THIS FORM IS TO BE PROVIDED TO THE INJURED WORKER WITH THE INITIAL REPORT OF INJURY**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 to be paid in the first three (3) days unless the disability prevents you from working for more than a total of fourteen (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.

The employer must provide a copy of this form to the injured worker with form 122E Employer's First Report of Injury. Additionally, the carrier/self-insured employer must provide a copy of this form to the injured worker with the initial injury report processed for the claim (Form 122C, 089, or 441).

FRAUD WARNING

Any person who knowingly presents false or fraudulent underwriting information, files, claim for disability compensation, medical benefits, health care fees, or other professional services are guilty of a crime and may be subject to fines and confinement in state prison.



ESTE FORMULARIO DEBE SER PROPORCIONADO AL TRABAJADOR LESIONADO CON EL INFORME INICIAL DE LESIÓN**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 reemplazo 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

El empleador debe proporcionar una copia de esta forma al trabajador lesionado junto con la forma 122E (primer reporte de accidente del empleador) adicionalmente la compañía de seguros o compañía auto asegurada debe proporcionar una copia de esta forma al trabajador lesionado junto con el primer reporte de accidente. (forma 122 c, 089, or 441).

ADVERTENCIA DE FRAUDE

Cualquier persona que a sabiendas presente información falsa o fraudulenta a la compañía de seguros, aplique por un reclamo por incapacidad, beneficios médicos, honorarios de atención médica u otros servicios profesionales, es culpable de un crimen y esta sujeto a multas o encarcelamiento en una prisión estatal.

