

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.

Workers' 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

G E N E R A L	Employer (Name & Address Include 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		
C L A I M S C A R R I E R A D M I N I S T R A T O R	CARRIER/CLAIMS ADMINISTRATOR									
	Carrier (Name, Address & Phone Number)			Policy Period		Claims Administrator (Name, Address & Phone Number)				
				To						
	Carrier FEIN			Policy/Self-Insured Number			Administrator FEIN			
Agent Name and Code Number										
E M P L O Y E E	EMPLOYEE/WAGE									
	Name (Last, First, Middle)			Date of Birth		Social Security Number		Date Hired	State of Hire	
	Address (Including Zip)			Sex	Male Female Unknown	Marital Status	Unmarried//single/Divorced Married Separated Unknown	Occupation / Job Title		
	Phone	Number of Dependents		M F U	U M S K			Employment Status		
Rate	Per:	Day	Month	Number of Days Worked/Week		Full Pay For Day of Injury	Did Salary Continue	Yes	No	
	Week	Other						No	No	
O C C U R R E N C E	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	YES	NO	
				Were They Used?						
T R E A T M E N T	Physician/Health Care Provider (Name & Address)			Hospital (Name & Address)			Initial Treatment			
							0	No Medical Treatment		
							1	Minor: By Employer		
							2	Minor: Clinic/Hospital		
							3	Emergency Care		
						4	Hospitalized - 24 hrs			
						5	Future Major Medical/Lost Time Anticipated			
O T H E R	OTHER									
	Witnesses (Name & Phone Number)									
	Date Administrator Notified		Date Prepared		Preparer's Name & Title			Phone Number		

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 the original of this report, **Worker’s Compensation Insurance Carrier** gets the **second copy**, the **employee** gets the **third** copy, and the employer gets the **fourth** and should maintain a copy of this report.
- * Failure to file this report with the Labor Commission or failure to provide the employee with 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