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		
	EMPLOYERS 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

EMPLOYEE NAME

NAME (LAST FIRST MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL. ZIP)	SEX: M MALE; F FEMALE; U UNKNOWN	MARITAL STATUS: U UNMARRIED SINGLE/DIVORCE; M MARRIED; S SEPARATED; K UNKNOWN	OCCUPATION / JOB TITLE	
			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 EMPLOYERS 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/HEATH 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-I (r1-1-02)

SEE BACK FOR IMPORTANT INFORMATION

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White. Labor Commission   Yellow: W C Insurance Carrier   Pink. Employee   Goldenrod Employers File