

For your protection Utah law requires notice that worker's compensation fraud is a crime. Please see the back of this form for the full fraud statement.

**Industrial Commission of Utah – Industrial Accidents Division**

P.O. Box 146610 · Salt Lake City, Utah 84114-6610

**Form 122**

**WORKERS COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS**

<b>GENERAL</b>	1. EMPLOYER (NAME & ADDRESS INCL. ZIP)		DATE SENT TO LABOR COMMISSION		CLAIM NUMBER			
	SALT LAKE COUNTY 2001 SO. STATE STREET SALT LAKE CITY, UTAH 84190  468-3421		JURISDICTION		JURISDICTION CLAIM NUMBER			
	SIC CODE 9131		EMPLOYER FEIN 87-6000 316		INSURED REPORT NUMBER			
			EMPLOYERS LOCATION ADDRESS (IF DIFFERENT)		LOCATION #			
<b>CLAIMS CARRIER ADMIN</b>	CARRIER (NAME, ADDRESS & PHONE NO.)		POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)			
	SALT LAKE COUNTY 2001 SO. STATE STREET #S3700 SALT LAKE CITY, UTAH 84190  468-3421		N/A TO N/A		SALT LAKE COUNTY RISK MANAGEMENT 2001 SOUTH STATE #S3700 SALT LAKE CITY, UTAH 84190-1200			
	CARRIER FEIN N/A		POLICY / SELF-INSURED MEMBER N/A		ADMINISTRATOR FEIN N/A			
	AGENT NAME & CODE NUMBER RISK MANAGEMENT		CHECK IF APPROPRIATE <input checked="" type="checkbox"/> SELF INSURANCE					
<b>EMPLOYEE</b>	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER		DATE HIRED	STATE OF HIRE UT	
	HOME ADDRESS (INCL ZIP)		SEX M MALE F FEMALE U UNKNOWN	MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SINGLE K UNKNOWN		OCCUPATION/JOB TITLE		
	PHONE		# OF DEPENDENTS			EMPLOYMENT STATUS		
						NCCI CLASS CODE		
<b>WAGE</b>	RATE	PER: <input type="text"/> DAY <input type="text"/> WEEK	MONTH <input type="text"/> OTHER: <input type="text"/>	# OF DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
	TIME EMPLOYEE BEGAN WORK	AM <input type="checkbox"/> PM <input type="checkbox"/>	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM <input type="checkbox"/> PM <input type="checkbox"/>	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
<b>OCCURRENCE</b>	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 THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
	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						CAUSE OF INJURY CODE	
	DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>TREATMENT</b>	PHYSICIAN/HEALTH CARE PROVIDER (NAMES & 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			
<b>OTHER</b>	WITNESSES (NAME & PHONE #)							
	YOU MUST LIST EMPLOYEE'S ASSIGNED STATION:							
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		SUPERVISOR'S SIGNATURE		PHONE NUMBER		