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.

Form 122

Industrial Commission of Utah – Industrial Accidents Division
P.O. Box 146610 · Salt Lake City, Utah 84114-6610
WORKERS COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

GENERAL

1. EMPLOYER (NAME & ADDRESS INCL. ZIP)

SALT LAKE COUNTY
2001 SO. STATE STREET
SALT LAKE CITY, UTAH 84190

468-3421

SIC CODE: 9131

EMPLOYER FEIN: 87-6000 316

DATE SENT TO LABOR COMMISSION:

CLAIM NUMBER:

JURISDICTION:

JURISDICTION CLAIM NUMBER:

INSURED REPORT NUMBER:

EMPLOYERS LOCATION ADDRESS (IF DIFFERENT):

LOCATION #:

PHONE #:

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO.)

SALT LAKE COUNTY
2001 SO. STATE STREET #S3700
SALT LAKE CITY, UTAH 84190

468-3421

POLICY PERIOD: N/A TO N/A

CHECK IF APPROPRIATE: [X] SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

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

EMPLOYEE

NAME (LAST, FIRST, MIDDLE):

DATE OF BIRTH:

SOCIAL SECURITY NUMBER:

DATE HIRED:

STATE OF HIRE: UT

HOME ADDRESS (INCL ZIP):

SEX: [ ] MALE [ ] FEMALE [ ] UNKNOWN

MARITAL STATUS: [ ] UNMARRIED SINGLE/DIVORCED [ ] MARRIED [ ] SINGLE [ ] UNKNOWN

OCCUPATION/JOB TITLE:

EMPLOYMENT STATUS:

PHONE:

OF DEPENDENTS:

NCCI CLASS CODE:

WAGE

RATE: PER: [ ] DAY [ ] WEEK [ ] MONTH [ ] OTHER:

OF DAYS WORKED/WEEK:

FULL PAY FOR DAY OF INJURY? [ ] YES [ ] NO

DID SALARY CONTINUE? [ ] YES [ ] NO

OCCURRENCE

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 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? [ ] YES [ ] NO

WERE THEY USED? [ ] YES [ ] NO

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAMES & 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

WITNESSES (NAME & PHONE #):

YOU MUST LIST EMPLOYEE'S ASSIGNED STATION:

DATE ADMINISTRATOR NOTIFIED:

DATE PREPARED:

SUPERVISOR'S SIGNATURE:

PHONE NUMBER: