

# Physician's Initial Report of Work Injury or Occupational Disease

**INSTRUCTIONS:** 1) form to be completed by physician; 2) copy of completed form to be sent to insurance carrier with bill and progress reports; 3) copy of form only sent to injured employee, employee's employer, and Utah Labor Commission.

*This report must be filled pursuant to rule R612-100-3 (A), Utah Administrative Code. For your protection Utah law requires notification that any workers' compensation fraudulent claim for disability compensation on medical benefits is a crime and may be subject to fines and prison confinement.*

**PLEASE PRINT OR TYPE**

<b>PHYSICIAN</b>	1. Physician Name			2. Physician Phone Number			<b>Do Not Use This Space</b> CLAIM NO. POLICY NO. Class Code
	3. Treatment Facility			4. Registered Email			
<b>CARRIER</b>	5. Insurance Company						
	6. Mailing Address		City		State		Zip
<b>PATIENT</b>	7. Employee's First Name			Middle Initial	Last Name		8. SS # (or other)
	9. DOB (MM/DD/YYYY)			10. Gender			
<b>EMPLOYER</b>	11. Mailing Address						
	City		State		Zip		12. Employee Telephone Number
<b>HISTORY</b>	13. Name of Employer						
	14. Address			City		State	
<b>EXAMINATION</b>	16. Date Injured (MM/DD/YYYY)			Hour	_____	AM	17. Last Date Worked
	_____			_____	PM		
<b>COMMENTS</b>	18. Employee's Statement of Cause of Injury or Illness (In First Person)						
	19. Diagnosis (Written Description as Related to Industrial Claim) w/ ICD Code						
	20. Is the Condition Requiring Treatment the Result of the Industrial Injury or Exposure Described?  Yes      No      Undetermined						
<b>COMMENTS</b>	21. Claimant Needs Interpreter      Yes      No      Language _____ (If Answer is Yes)						
	22. Other Comments						
23. Date Submitted _____							



**Official Form 123** Revised 10/14

**State of Utah \* Labor Commission \* Division of Industrial Accidents**

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