

Insurance Company's and Self Insurer's Final Report of Injury and Statement of Total Losses

PLEASE PRINT OR TYPE

INSTRUCTIONS: This final report MUST BE FILED as soon as possible, but not later than thirty (30) days after final payments are made in all workers' compensation cases. List ALL medical payments made, even if reimbursed by the Employers' Reinsurance Fund. This form is to be filed when an Order is entered.

Employer's Name: _____

Employer's Address _____ Zip: _____

Employee's Name: _____ Date of Injury: _____

Employee's Social Security Number: _____

When was employee physically able to return to work? _____

Light Duty/Part-Time: _____ Full duty _____
(Indicate Period of Time)

Actual **number of days** injured was absent from work: _____

PAYMENTS

Temporary Total for: _____ weeks at \$ _____ for a total of \$ _____

Temporary Partial: _____ weeks at \$ _____ for a total of \$ _____

Permanent Partial: _____ weeks at \$ _____ for a total of \$ _____

Survivor Benefits for: _____ weeks at \$ _____ for a total of \$ _____

Medical: \$ _____

Vocational Rehabilitation: \$ _____

Travel Expenses and per diem: \$ _____

Date of this report: _____ **TOTAL:** \$ _____

Insurance Company

Adjusting Firm

Printed Name of Adjuster

Signature of Adjuster

Adjuster's Phone Number

Adjuster's Mailing Address

Mail the original of this form to the employee and a copy to the Labor Commission



Official Form 130 Revised 10/14

State of Utah * Labor Commission * Division of Industrial Accidents

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