Form 130

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