Form 122E

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

Revised 7/2024

TO BE COMPLETED BY EMPLOYER WITH ORIGINAL SENT TO INSURANCE CARRIER AND COPY SENT TO INJURED WORKER

INJURED WORKER INFORMATION:

Name:	Phone:
Address:	City: State: Zip:
Social Security Number:	Date of Birth:
Marital Status:	Sex: Male ☐ Female ☐ Unknown ☐
Occupation / Job Title:	Date Hired:
Employment Status:	Number of Dependents:
Wage: Wage Period: ☐ Hourly ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly	
Full Pay for Day of Injury: Yes ☐ No ☐	Number of Days Worked per Week:

EMPLOYER INFORMATION:

Business Name:	Phone:
Employer Contact:	Phone:
Mailing Address:	City: State: Zip:
Employment Address:	City: State: Zip:
Employer FEIN:	

INSURANCE INFORMATION:

Carrier:	Phone:
Carrier Address:	City: State: Zip:
Claim Administrator:	Phone: Email:
Administrator Address:	City: State: Zip:
Policy / Self-Insured Number:	Jurisdiction Claim Number (JCN):
Claim Administrator Claim Number:	Policy Period:

OCCURRENCE/TREATMENT:

Date of Injury / Disease:	Time of Injury:	Date Employer Notified:
Nature:	Body Part:	Cause:
Last Day Worked:	Date Disability Began:	Date Returned to Work:
Fatality: Yes ☐ No ☐	Date of Death:	Date Administrator Notified:

Address of Occurrence: City: State: Zip:

Premises: Employer's ☐ Other ☐ Description:

Accident Description:

Provider Injured Worker Received Care From:

Provider Address : City: State: Zip:

Treating Physician: Phone:

Initial Treatment: No Medical Treatment ☐ Minor: By Employer ☐ Minor: Clinic/Hospital ☐ Emergency Care ☐
Hospitalized- 24 Hours ☐ Future Major Medical/Lost Time Anticipated ☐

Witnesses: Yes ☐ No ☐ If yes list their names and phone number:

For your protection, it is required by Utah Law to give notice that workers' compensation fraud is a crime. See next page for full fraud statement.

UTAH LABOR COMMISSION
Industrial Accidents Division

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 www.laborcommission.utah.gov

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INSTRUCTIONS TO THE EMPLOYER

PLEASE NOTE:

The filing of this form does not admit liability or fault. However, failure to file this report with the insurance carrier and provide a copy to the injured worker can result in a citation and civil penalty for each violation as per §34A-2-407(8), U.C.A.

The insurance carrier is to receive the original of this form. The injured worker shall then receive a copy along with their rights and obligations of the Utah's Workers' Compensation Act (Form 100). The employer should keep a copy for their records. The Labor Commission, Division of Industrial Accidents, will receive an electronic copy from the insurance carrier. The electronic copy of this form is private information and only released to parties of the claim.

In order to dispute the validity of the injured worker's claim, contact the insurance carrier or claim administrator for more information.

All fields on this form are required. Please complete this form entirely and do not leave any blank fields. This form will be returned and additional information will be requested if it is not properly completed. If you, the employer, need assistance to complete the form contact your workers' compensation insurance carrier or claims administrator.

Rule R612-200-1(A)(2) Except for injuries treated only by first aid, an employer shall report each employee work injury within 7 days after receiving initial notice of the injury, as follows:

a. An employer that has obtained workers' compensation insurance shall report the injury to its insurance carrier.

b. An employer that has received Division authorization to self-insure shall report the injury to its claims administrator.

c. An employer that has failed to obtain worker's compensation coverage shall report the injury by contacting the Division directly.

3. An employer has notice of a work injury upon the earliest of:

a. Observation of the injury;

b. Verbal or written notice of the injury from any source; or

c. Receipt of any other information sufficient to warrant further inquiry by the employer.

FRAUD WARNING:

Any person who knowingly presents false or fraudulent underwriting information, files a claim for disability compensation, medical benefits, health care fees, or other professional services, are guilty of a crime and may be subject to fines and confinement in state prison.

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