Form 219

Statement of Compensation

Applicant's Name _____ DOI _____

Street Address _____ Social Security Number _____

City/State, Zip _____ DOB _____

Employer _____

Insurance Carrier/Adjusting Service Address_____

City/State/Zip _____ Telephone _____ Fax _____

Adjuster Name _____ Adjuster Email_____

Temporary Total Disability (TTD) Total Paid:_____.

_____ **No Lost Time. (If no lost time, please attach verification of salary at the time of injury.)**

Total Number of Lost Work Days:_____.

Temporary Partial Disability (TPD) paid_____for a total of_____of which_____has been paid.

Total Medicals Paid to Date_____.

Pursuant to the attached medical report and the applicable law, the applicant is entitled to **Permanent Partial Disability Compensation (PPD)** at the rate of $_____per week, commencing _____ for_____weeks, totaling $_____, for a_____% impairment of the _____ _____ due to his/her industrial injuries, (of which $_____has been advanced).

The Labor Commission shall retain continuing jurisdiction to modify awards as provided by law. Medical expenses incurred as a result of the industrial injury are the continuing obligation of the employer/carrier. Medical care becomes a lifetime benefit so long as the insurance carrier/employer is billed within one year from the date of each medical service (§34A-2-417). Accrued amounts of compensation will be paid in a lump sum. The remaining amount will be paid as due.

NOTE: Compensation is tax exempt for Federal and State Income Tax purposes.

ADJUSTOR NOTE: Forms 122, 123, 141 and the PPI rating are to be maintained by carriers and self-insured employers indefinitely and are to be made available to the Labor Commission upon request.

****Per R612-200-3, the completed form and supporting documents shall be sent to the claimant or dependents but do not need to be filed with the Division unless requested.**

UTAH LABOR COMMISSION
Industrial Accidents Division

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