

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.

PHYSICIAN	1. Physician Name			2. Physician Phone Number			<u>Do Not Use This Space</u> CLAIM NO. POLICY NO. Class Code
	3. Treatment Facility			4. Registered Email			
CARRIER	5. Insurance Company						
	6. Mailing Address		City		State		Zip
PATIENT	7. Employee's First Name			Middle Initial	Last Name		8. SS # (or other)
	11. Mailing Address			City	State	Zip	
							10. Gender
							12. Employee Telephone Number
EMPLOYER	13. Name of Employer						
	14. Address			City	State	Zip	15. Employer Telephone Number
HISTORY	16. Date Injured (MM/DD/YYYY)			Hour _____	AM	17. Last Date Worked	
				_____	PM <input type="checkbox"/>		
18. Employee's Statement of Cause of Injury or Illness (In First Person)							
EXAMINATION	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?						
	<input type="checkbox"/> Yes <input type="checkbox"/> No Undetermined						
21. Claimant Needs Interpreter			Yes	No	Language _____ (If Answer is Yes)		
COMMENTS	22. Other Comments						
	23. Date Submitted _____						

