Rev 5/2025

Form 123

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 (H), 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. You may send the form to the division fax at 801-530-6804.

PHYSICIAN

1. Physician Name
2. Physician Phone Number
3. Treatment Facility
4. Registered Email

Do Not Use This Space
CLAIM NO.
POLICY NO.
Class Code

CARRIER

5. Insurance Company
6. Mailing Address City State Zip

PATIENT

7. Employee's First Name Middle Initial Last Name
8. SS # (or other)
9. DOB (MM/DD/YYYY)
10. Gender
11. Mailing Address City State Zip
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 ☐ PM ☐
17. Last Date Worked
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?

☐ Yes ☐ No Undetermined ☐

21. Claimant Needs Interpreter Yes ☐ No ☐ Language_____(If Answer is Yes)

COMMENTS

22. Other Comments
23. Date Submitted _____

UTAH LABOR COMMISSION
Industrial Accidents Division

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