

Physician's Initial Report of Work Injury or Occupational Disease

This report must be filed pursuant to rule R568-2-3-(A)

For your protection Utah law requires notification that any workers' compensation fraudulent claim for disability compensation or medical benefits is a crime and may be subject to fines and confinement in the state prison.

Industrial Commission - Industrial Accidents Division

160 East 300 South 3rd Floor, P.O. Box 146610, Salt Lake City, Utah 84114-6610

Please Print or Type

Insurance Company:		Do Not Use This Space	
Address:		Claim No.	
		Policy No.	
		Class Code.	
1. Employee's First Name:	Middle Initial:	Last Name:	2. Social Security No.:
3. DOB:		4. Sex:	
5. Street Address:	City:	State:	Zip:
6. Phone No.:		7. Ht.:	8. Wt.:
9. Name of Employer:		10. Address:	
11. Phone No.:			
12 Date Injured:	Hour:	<input type="text"/> AM <input type="text"/> PM	13. Last Date Worked:
14a. Has This Part Been Injured Before?		<input type="text"/> yes <input type="text"/> no	
14b. If "Yes" State When and Describe:			
15. Employee's Statement of Cause of Injury or Illness (In First Person):			
16. Describe Complaints (In First Person):			
17. Findings of Examination:			
18. X-Rays? <input type="text"/> Yes <input type="text"/> No		19. ICD-9 Codes:	
Findings:		_____ - _____	
20. Diagnosis (Written Description)		_____ - _____	
_____ - _____			
21. Is the Condition Requiring Treatment the Result of the Industrial Injury or Exposure Described?			
<input type="text"/> yes <input type="text"/> no <input type="text"/> Undetermined If "No" Explain:			
22. Date of First Treatment:		Hour:	23. Type of Treatment:
		<input type="text"/> AM <input type="text"/> PM	
24. If Hospitalized, What Hospital?		In-Patient	Out-Patient
25. If case Referred to Another Physician, Give Physician's Name and Address			
26. Is Condition Medically Stationary?		27. Is Any Further Treatment Required?	
<input type="text"/> yes <input type="text"/> no		<input type="text"/> yes <input type="text"/> no	
		If "Yes" Date of Next Visit and How Many Estimated?	
28. Will Injury Cause Permanent Impairment?		<input type="text"/> yes <input type="text"/> no	
29. Does Injury Prevent Return to Regular Employment?		Modified Employment?	
<input type="text"/> yes <input type="text"/> no If "Yes" Estimate Time Loss:		<input type="text"/> yes <input type="text"/> no	
		If "Yes" Explain Restrictions:	
30. Date Released for Work:			
31. Remarks or Outline of Proposed Treatment:			
32. Are There Any Conditions That Would Retard or Prevent Recovery? <input type="text"/> yes <input type="text"/> no			

33. Name of Physician and Degree:		34. Address:		35. Phone No.:
36. Federal Tax I.D. Number		37. Date:	38. Signature (Physicians Own Signature Please):	
White: Industrial Commission	Yellow: Employee	Pink: Insurance Carrier	Goldenrod: Physicians' File	

Workers Comp. Info. For Employer

Employee Name: _____

Work Limitations: _____

How Long Do You Anticipate Limitations? _____

How Much Weight Is Employee Able To Lift? _____

Is Employee Able To Do Sedentary Work? _____