FIRST REPORT OF INJURY - Workers' Compensation

****Please notify Human Resources and your direct supervisor immediately.****

NAME ______________________ SOCIAL SECURITY NUMBER ______________ DATE OF BIRTH ______________

MAILING ADDRESS ______________________ EMAIL ADDRESS ______________________

CITY & STATE (INCLUDING ZIP) ______________________

DEPARTMENT______________________ SUPERVISOR______________________

NUMBER # OF DEPENDENTS__________ SINGLE ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN ☐ SEX M☐ or F☐

HOME PHONE______________ WORK PHONE______________ CELL PHONE______________

DATE OF INJURY/ILLNESS ______________ TIME OF OCCURRENCE ______ AM☐ PM☐ TIME EMPLOYEE BEGAN WORK ______ AM☐ PM☐ If disability - list date disability began ______________

DATE EMPLOYER NOTIFIED ______________ **PERSON** NOTIFIED ______________ PHONE NUMBER ______________

PART OF **BODY** AFFECTED ______________ **TYPE OF INJURY/ILLNESS** (I.E. CUT, BRUISE, BURN, FRACTURE, ETC.) ______________

DEPARTMENT OR **LOCATION** WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED, INCL. ZIP ______________________

ALL **EQUIPMENT**, MATERIALS, OR CHEMICALS EMPLOYEE WAS **USING** WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED ______________________

WERE **SAFEGUARDS** OR SAFETY EQUIPMENT PROVIDED? YES☐ NO☐ WERE THEY USED? YES☐ NO☐

DESCRIBE THE **SEQUENCE OF EVENTS**

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____

____

PHYSICIAN or HEALTH CARE PROVIDER that provided treatment (Name, Address and zip code)

____

____

____

HOSPITAL (Name, Address and Zip code)

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TREATMENT RECEIVED: NO MEDICAL TREATMENT ☐ *MINOR: BY EMPLOYER ☐ *MINOR CLINIC/HOSPITAL ☐
EMERGENCY CARE ☐ *HOSPITALIZED>24 HRS ☐ **FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED ☐

WITNESSES ______________________ PHONE NUMBER ______________

Special Note: Employees must also complete and sign the Industrial Options form (benefitted employees) and Days Missed form (all employees). Please return completed form to karena@utahcounty.gov

Updated 6/9/2021