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 nay workers' compensation fraudulent claim for disability compensation or medical benefits is a crime and may be subject to fines and confinement in the sate 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

<table>
<tr><td colspan="4">Insurance Company:

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

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?_____