TOOELE COUNTY

WORKERS COMPENSATION CLAIM (FORM 122)

This form must be filled out completely.
Additional space is provided at the end, if needed.

EMPLOYEE NAME_____ **HOME PHONE**_____

ADDRESS _____**CITY, STATE, ZIP**_____

SOCIAL SECURITY #_____**DRIVER LICENSE #**_____ **ISSUING STATE**_____

MARITAL STATUS_____**# DEPENDENTS**_____ **DATE OF BIRTH** _____ **JOB TITLE**_____

DEPARTMENT_____ **SUPERVISOR NAME**_____ **PHONE**_____

 # OF DAYS WORKED PER WEEK_____**# OF HOURS WORKED PER WEEK**_____**LAST DAY WORKED** _____

DATE OF ACCIDENT_____**TIME OF ACCIDENT**_____**TIME BEGAN WORK**_____

DATE EMPLOYER NOTIFIED_____ **WHO DID YOU NOTIFY** _____**TIME**_____

IF NOTIFICATION OR REPORT WAS DELAYED, DESCRIBE THE REASON_____

_____

LOCATION AND ADDRESS WHERE ACCIDENT OCCURRED_____

_____

SPECIFICALLY DESCRIBE THE ACCIDENT: Additional space available at the end of the report.

HOW DID THE ACCIDENT OCCUR _____

_____

DESCRIBE THE WORK BEING PERFORMED _____

_____

_____

WAS THIS YOUR REGULAR DUTY _____ **IF NO, WERE YOU TRAINED FOR THIS AND BY WHOM?** _____

_____

WAS SAFETY EQUIPMENT PROVIDED_____**WHAT WAS THE SAFETY EQUIPMENT** _____

_____

WAS IT USED _____ **IF NO, EXPLAIN WHY?** _____

_____

WHO WAS INVOLVED_____

_____

WEATHER CONDITIONS _____**ROAD CONDITIONS** _____**SPEED**_____

DESCRIBE IN DETAIL, THE DAMAGE DONE TO COUNTY PROPERTY/EQUIPMENT/VEHICLE

_____

_____

_____

WAS A POLICE REPORT TAKEN_____WHICH AGENCY_____NAME OF OFFICER_____

COUNTY VEHICLE OR EQUIPMENT BEING OPERATED _____EQUIPMENT # _____

LICENSE PLATE #_____VIN #_____

EMPLOYEE INJURY

NO INJURY _____

SPECIFICALLY DESCIRBE THE INJURY IN YOUR OWN WORDS AND ALSO MARK THE BOXES COORESPONDING TO THE INJURY

PART OF BODY		TYPE OF INJURY/EXPOSURES	CAUSE
_____HEAD	____WRIST	_____PUCTURE WOUND	_____FALL
_____EYES	____HAND	_____FOREIGN BODY	_____SLIP
_____NOSE	____FINGER	_____SPRAIN/STRAIN	_____SPILL-SPRAY
_____MOUTH	____HIP	_____HERNIA	_____STRUCK BY PERSON
_____EAR	____THIGH	_____LACERATION	_____STRUCK BY EQUIP.
_____NECK	_____KNEE	_____FRACTURE	_____STRUCK BY OBJECT
_____LEG	_____SHOULDER	_____DISLOCATION	_____PULLING/PUSHING
_____ANKLE	_____BACK, UPPER	_____INFECTIOUS DISEASE	_____LIFTING
_____FOOT	_____BACK, LOWER	_____BURN/SCALD	_____BENDING/REACHING
_____CHEST	_____TOES	_____IRRITATIONS	_____EXPOSURE
_____ARMS	_____INTERNAL	_____RESPIRATORY	_____OVEREXERTION
INDICATE	LEFT____OR RIGHT____	_____OTHER	_____OTHER

_____

_____

_____

_____

MEDICAL TREATMENT – NAME, ADDRESS & PHONE OF PHYSICIAN

- **NO TREATMENT**
- **MINOR TREATMENT BY EMPLOYER** _____
- **TREATMENT BY PRIVATE PHYSICIAN** _____
- **EMERGENCY CARE – Rescue and/or Hospital** _____
- **HOSPITALIZED MORE THAN 24 HOURS** _____
- **MAJOR MEDICAL** _____

OTHER VEHICLE AND/OR PROPERTY

NAME OF OWNER _____ADDRESS_____PHONE_____

NAME OF DRIVER_____ADDRESS _____PHONE_____

VEHICLE PLATE #_____VIN#_____MAKE & MODEL _____

DAMAGED PROPERTY _____

SECOND PARTY INJURY: DESCRIBE THE INJURY TO THE OTHER PERSON(S) TO THE BEST OF YOUR KNOWLEDGE

_____

_____

_____

_____

WITNESS(ES):

WITNESS NAME_____ **PHONE**_____

ADDRESS _____**CITY, STATE, ZIP**_____

WITNESS NAME_____ **PHONE**_____

ADDRESS _____**CITY, STATE, ZIP**_____

ADDITIONAL EMPLOYEE COMMENTS

_____

_____

_____

_____

_____

SUPERVISOR COMMENTS

_____

_____

_____

_____

_____

SAFETY COORDINATOR COMMENTS

_____

_____

_____

EMPLOYEE SIGNATURE_____**DATE**_____

SUPERVISOR SIGNATURE_____**DATE**_____

H.R DEPARTMENT SIGNATURE_____**DATE**_____

SAFETY COOR. SIGNATURE_____**DATE**_____

HUMAN RESOURCE DEPARTMENT ONLY

STATE OF HIRE_____**DATE HIRED**_____**EMPLOYMENT STATUS**_____

RATE OF PAY_____**DATE RETURNED TO WORK**_____

DATE REPORT FILED WITH Traveler's_____**NAME OF OPERATOR**_____