



WORKERS COMPENSATION CLAIM (FORM 122)

THIS FORM MUST BE FILLED OUT COMPLETELY.
USE BACK OF FORM, IF ADDITIONAL SPACE IS NEEDED.

EMPLOYEE INFORMATION

NAME: _____
HOME PHONE: _____ ADDRESS: _____
CITY, STATE, ZIP CODE: _____
SOCIAL SECURITY #: _____ MARITAL STATUS: _____ # OF DEPENDENTS: _____
DATE OF BIRTH: _____ JOB TITLE: _____ DEPARTMENT: _____
SUPERVISOR'S NAME: _____ PHONE: _____
OF DAYS WORKED PER WEEK: _____ # OF HOURS WORKED PER WEEK: _____ LAST DAY WORKED: _____

DESCRIPTION OF ACCIDENT

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____ TIME WORK BEGAN: _____
DATE AND TIME EMPLOYER WAS NOTIFIED: _____ NAME OF PERSON NOTIFIED: _____
IF NOTIFICATION OR REPORT WAS DELAYED, DESCRIBE THE REASON: _____

LOCATION AND ADDRESS WHERE ACCIDENT OCCURRED: _____

DESCRIBE HOW THE ACCIDENT OCCURRED: _____

DESCRIBE THE WORK BEING PERFORMED: _____

WAS THE WORK BEING PERFORMED THE EMPLOYEE'S REGULAR DUTY? _____
IF NO, WAS THE EMPLOYEE TRAINED? _____ IF YES, WHO PROVIDED THE TRAINING? _____
WAS SAFETY EQUIPMENT PROVIDED? _____ IF YES, WHAT WAS THE SAFETY EQUIPMENT? _____

WAS THE SAFETY EQUIPMENT USED? _____ IF NOT, EXPLAIN WHY: _____

LIST THE NAME(S) & PHONE NUMBER(S) OF OTHERS INVOLVED: _____

DESCRIPTION OF INJURY

NO INJURY _____

MARK THE BOXES COORESPONDING TO THE INJURY AND SPECIFICALLY DESCRIBE THE INJURY IN YOUR OWN WORDS:

- | <u>PART(S) OF BODY</u> | | <u>TYPE OF INJURY</u> | <u>CAUSE</u> |
|--------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> HEAD | <input type="checkbox"/> WRIST | <input type="checkbox"/> PUCTURE WOUND | <input type="checkbox"/> FALL |
| <input type="checkbox"/> EYES | <input type="checkbox"/> HAND | <input type="checkbox"/> FOREIGN BODY | <input type="checkbox"/> SLIP |
| <input type="checkbox"/> NOSE | <input type="checkbox"/> FINGER | <input type="checkbox"/> SPRAIN/STRAIN | <input type="checkbox"/> SPILL-SPRAY |
| <input type="checkbox"/> MOUTH | <input type="checkbox"/> HIP | <input type="checkbox"/> HERNIA | <input type="checkbox"/> STRUCK BY PERSON |
| <input type="checkbox"/> EAR | <input type="checkbox"/> THIGH | <input type="checkbox"/> LACERATION | <input type="checkbox"/> STRUCK BY EQUIPMENT |
| <input type="checkbox"/> NECK | <input type="checkbox"/> KNEE | <input type="checkbox"/> FRACTURE | <input type="checkbox"/> STRUCK BY OBJECT |
| <input type="checkbox"/> LEG | <input type="checkbox"/> SHOULDER | <input type="checkbox"/> DISLOCATION | <input type="checkbox"/> PULLING/PUSHING |
| <input type="checkbox"/> ANKLE | <input type="checkbox"/> BACK, UPPER | <input type="checkbox"/> INFECTIOUS DISEASE | <input type="checkbox"/> LIFTING |
| <input type="checkbox"/> FOOT | <input type="checkbox"/> BACK, LOWER | <input type="checkbox"/> BURN/SCALD | <input type="checkbox"/> BENDING/REACHING |
| <input type="checkbox"/> CHEST | <input type="checkbox"/> TOES | <input type="checkbox"/> IRRITATIONS | <input type="checkbox"/> EXPOSURE |
| <input type="checkbox"/> ARMS | <input type="checkbox"/> INTERNAL | <input type="checkbox"/> RESPIRATORY | <input type="checkbox"/> OVEREXERTION |
| | | <input type="checkbox"/> EXPOSURE | <input type="checkbox"/> OTHER |

INDICATE IF INJURY WAS ON:
 RIGHT OR LEFT

EXPLAIN: _____

EMPLOYEE SIGNATURE: _____ DATE: _____

MEDICAL TREATMENT

- NO TREATMENT; FIRST AID REPORT
- MINOR TREATMENT BY EMPLOYER
- TREATMENT BY PRIVATE PHYSICIAN
- WORX CLINIC
- EMERGENCY CARE
- HOSPITALIZED MORE THAN 24 HOURS
- MAJOR MEDICAL

PHYSICIAN INFORMATION

NAME: _____ PHONE: _____

ADDRESS: _____ CITY, STATE, ZIP CODE: _____

SUPERVISOR STATEMENT

Include the employee's duties as they relate to the incident. If there was an occupational exposure to blood or other potentially infectious materials, as defined in the Tooele County Bloodborne Pathogens Exposure Control Plan, document the circumstances under which exposure occurred and complete the BLOOD EXPOSURE PACKET.

NAME OF SUPERVISOR: _____ PHONE: _____

DEPARTMENT: _____

NAME OF INJURED WORKER: _____

DATE OF ACCIDENT: _____

DESCRIBE WHAT HAPPENED: _____

SUPERVISOR SIGNATURE: _____ DATE: _____

SUPERVISOR'S STATEMENT

Name of injured worker: _____

Date of accident: _____

Name of Supervisor: _____

Department: _____

What happened: (Include their duties as they relate to the incident, the route of Bloodborne Exposure and circumstances under which exposure occurred.

Signature: _____

Date: _____

WITNESS STATEMENT(S)

WITNESS NAME: _____ PHONE: _____

ADDRESS: _____ CITY, STATE, ZIP CODE: _____

NAME OF INJURED WORKER: _____

DATE OF ACCIDENT: _____

DESCRIBE WHAT HAPPENED: _____

WITNESS SIGNATURE: _____ DATE: _____



WITNESS NAME: _____ PHONE: _____

ADDRESS: _____ CITY, STATE, ZIP CODE: _____

NAME OF INJURED WORKER: _____

DATE OF ACCIDENT: _____

DESCRIBE WHAT HAPPENED: _____

WITNESS SIGNATURE: _____ DATE: _____