Utah School Boards Risk Management Mutual Insurance Association

Employee Information

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Preference Phone G Email G

Married G Yes G No # of Children under 18 \_\_\_\_

Accident Information

Date/Time of Accident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ During regular work hours/duties? G Yes G No

List any Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were you at your regular work location? G Yes G No

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If no to either, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe in detail how accident happened \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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860 E 9085 S Sandy Utah 84094

Treatment Information

Were you treated for your injury? G Yes G No

If yes, where were you seen?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 List Name of Clinic/Hospital and Doctor (If Known)

Additional treatment recommended? G Yes G No

 If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you will be seen more than three times, remember to complete the Release of Protected Health Information and the Medical Treatment Provider list and return with this form. If you were seen 1-3 times and released from care, return just this form.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Injury Information

Describe Injuries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the doctor take you off work? G Yes G No

Expected Return to Work Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the past, have you had an injury or treatment to the same part of body? G Yes G No

 If yes, who treated you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Approximate date last seen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Information

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gross Pay per Week $ \_\_\_\_\_\_\_\_\_\_\_

Second job? G Yes G No

Name of 2nd Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_