Utah Office for Victims of Crime
350 East 500 South, Suite 200
Salt Lake City, UT 84111
Phone (801)-238-2360, Toll Free (800)621-7444
Email crimevictims@utah.gov

CLAIM FOR CRIME RELATED LOSS OF WAGES

Must be completed by Health Care Provider

Claimant's Name: _____Victim's Name: _____Claim: _____

If you are claiming loss of wages for an extended amount of time missed, this form MUST be completed and submitted to the Utah Office for Victims of Crime by the health care provider who treated you.
Si reclama una pérdida de sueldo por una cantidad prolongada de tiempo perdido, este formulario se debe completar y enviar a la Oficina de Utah para Victimas de Crimen por el proveedor de atención médica que lo atendió.

Health Care Provider please answer the following questions:

1. Patient's Name:_____ Date of Birth: _____
2. Patient Address: _____
   _____ Phone: _____
3. Date of Incident:_____ Date first seen for reported incident: _____
4. Did diagnosed condition result from reported incident? _____
5. Please explain in detail what patient was seen for. Give a brief history of injuries, expected treatment, and include any procedure(s) and ICD Codes._____
   _____
   _____
   _____
   _____
6. Is there any pre-existing impairment of the injured area? If so please explain:_____
   _____
   _____
7. Estimated dates patient will be off work due to listed injury or mental health concerns:
   a. From:_____ To: _____
8. Name and phone number of physician(s) you referred patient to:_____
   _____
9. Location where Patient was seen by Health Care Provider:_____
10. Health Care Provider's name: _____Phone:_____
11. Health Care Provider's address: _____
    _____

_____ _____
Health Care Provider's Signature Date

Please submit completed form to the address listed above. If there are any questions or concerns, please contact our office.