

INSTRUCTIONS

Every **FATAL, PERMANENT TOTAL AND PERMANENT PARTIAL** claim on which compensation is payable by your company, must be entered on this form and carried forward on subsequent reports until paid out. New cases will be entered as they are determined and carried forward on the next report. (Be sure to disregard all Total Temporary cases.)

File report by the 10th of the month.

HEADING: PRINT NAME OF INSURER OR SELF-INSURED EMPLOYER, YEAR AND SELECT CALENDAR ENDING QUARTER.

COLUMN 1. DATE OF INJURY

COLUMN 2. NAME OF INJURED EMPLOYEE

COLUMN 3. CLASS OF DISABILITY

Enter in this column the kind of case; i.e., FATAL, PERMANENT TOTAL, OR PERMANENT PARTIAL. (Use Abbreviations)

COLUMN 4. TOTAL AWARDS

Include total compensation and other expenses as shown on the approved Summary of Payments and/or Reserves established for Permanent Totals.

COLUMN 5. COMPENSATION PAID

Enter the amount paid on each case since the last report was filed.

COLUMN 6. TOTAL COMPENSATION PAID

Enter the total amount paid on the award, including amount shown in column 5.

COLUMN 7. ADJUSTMENT

Make all adjustments for changes of conditions, remarriage, deaths, errors, etc. in this column. If adjustments are made, then column 4 must equal column 6 plus or minus column 7 plus column 8.

COLUMN 8. UNPAID BALANCE

This will show the balance due on each case.

THIS FORM MUST BE COMPLETED AND EXECUTED DIRECTLY BY THE SURETY OR SELF-INSURED EMPLOYER

**MAIL TO: IDAHO INDUSTRIAL COMMISSION
FISCAL SECTION
P. O. BOX 83720
BOISE, ID 83720-0041**

PHYSICAL ADDRESS: IDAHO INDUSTRIAL COMMISSION
FISCAL SECTION
700 S CLEARWATER LANE
BOISE, ID 83712

If you have any questions, please contact one of the following Financial Specialists. If your company name begins with A through I, please contact Therese Ryan at (208) 334-6095. If your company name begins with J through Z, please contact Dianne Johnson at (208) 334-6026.

**IC 36, REPORT OF OUTSTANDING AWARDS FOR FATAL, PERMANENT PARTIAL
IMPAIRMENT, AND PERMANENT TOTAL DISABILITY CLAIMS**

(Name of Insurer or Self-Insured Employer)

Year: _____

For Calendar Quarter Ending: March June September December

(1) Date Of Injury	(2) Claimant Name (as shown on First Report of Injury)	(3) Type of Claim	(4) Total Awards	(5) Compensation on this Report	(6) Total Compensation Paid	(7) Adjustment	(8) Unpaid Balance
Total							

Send Original to: Fiscal Section, Industrial Commission, P.O. Box 83720, Boise, Idaho 83720-0041

Corporate Officer's Signature and Title _____

Printed Name _____

Date: _____

Print Name and Title of Preparer: _____

Company: _____

Address: _____

Telephone: _____

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