STATE OF IDAHO

SUMMARY OF PAYMENTS

NON-FATAL CASES

IC No. _____ County:_____ SSN:_____

Surety Claim No.:_____ Policy Yr._____

Injured Person:_____ Employer:_____

Address: _____ Business:_____

_____ Address:_____

Occupation:_____ _____

Character of Injury:_____

Date of Injury:_____ Weekly Wage: _____

Date RTW: _____ Comp. Rate: _____

Last check date:_____

INDEMNITY							MEDICALS	
Dis-abil--ity Type	$ Amounts		wks	days	Beginning Date of Disability	Last Date of Disability	Service Type	$ Amount
	$ Total	$/Wk rate						
							DOCTOR	
							HOSP	
							PHYS TH	
							MILEAGE	
							MISC	

Note: A new period of disability must be itemized each time Comp Rate changes; or Type of Disability changes; or there is a break in continuity.

Notes: Industrial Commission Approval:

Surety: _____

Adjuster: _____

by:_____Date:_____

IC FORM 6(7-1-97)