STATE OF IDAHO

SUMMARY OF PAYMENTS

NON-FATAL CASES

IC No: **DN0005** County: **N/A** SSN: **DN0042**

Surety Claim No: **DN0015** Policy Year: **DN0029** - **DN0030**

Injured Person: **DN0044 DN0043** Employer: **DN0018**

Address: **DN0046** Address: **DN0019**

DN0048, DN0049 DN0050 **DN0021, DN0022 DN0023**

Occupation: **DN0060**

Character of Injury: **DN0035 DN0036**

Date of Injury: **DN0031** Weekly Wage: **DN0286**

Date RTW: **DN0072** Comp Rate: **DN0134**

INDEMNITY							MEDICALS	
Disability Type	Amounts		Weeks	Days	Beginning Date of Disability	Last Date of Disability	Service Type	$ Amount
	$ Total	$/Wk Rate						
DN0085	**DN0086**	**DN0087**	**DN0090**	**DN0091**	**DN0088**	**DN0089**	DOCTOR	
							HOSPITAL	
							PT	
							MILEAGE	
							OTHER	
							DN0216	**DN0215**

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: **DN0084, DN0083** Industrial Commission Approval:

Surety: **DN0007**

Adjuster: **DN0188**

By: **DN0140** Date: _____