WORKERS' COMPENSATION
EMPLOYEE'S REPORT OF A WORK-RELATED INJURY

Greeley-Evans
WELD COUNTY SCHOOL DISTRICT 6

This form must be filled out when an employee is injured while in the course of employment. Complete this accident report within 24 hours after suffering a work–related injury, and send this form to the Risk Management Specialist at the Administration Bldg., along with a signed copy of the Employee Choice of Designated Work Comp Medical Provider Form. (Fax # 348-6034)

EMPLOYEE SECTION: PLEASE COMPLETE EVERY ITEM:

Name:_____ Social Security No.:_____
First Middle Initial Last

Date of Birth:____/____/____ Marital Status:_____ ☐ Female ☐Male

Home Address:_____ Home Phone:_____
City and Zip Code

Job Assignment:_____ Bldg Where Assigned:_____

No. of Hrs worked per day:_____ No. of days worked per week:_____ Work schedule begins at _____ Ends at_____

INJURY INFORMATION:

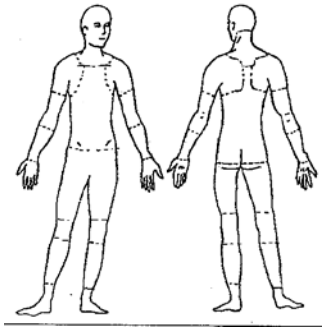
Date of Injury:_____ Time of Injury_____(AM or PM)

Did you miss any time from work because of injury? ☐ YES ☐ NO

If YES, date of last day worked: _____ No. of Hrs off work:_____ Date you returned to work:_____

Describe in DETAIL the circumstances of how and why the injury occurred:_____

Describe in DETAIL the injury to include specific body part(s) affected, i.e. right or left, etc.: _____



Location and Exact Address of Injury or Accident:_____

Name and Work Number of Witness(es):_____

THIRD Party Information (if involved in Motor Vehicle Accident):_____

DID YOU SEEK MEDICAL TREATMENT FOR THIS INJURY? ☐ YES ☐ NO

IF YES, List Name and Address of Treating Physician for this Injury:_____

Name and Address of Hospital if applicable:_____

Name of Immediate Supervisor Notified: Date Notified:

SIGNATURE OF EMPLOYEE: DATE:

C.R.S. Section 10-1-127(7)(a) states "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies."

After completion of this form – give to your supervisor for completion of next page. Please CALL Pam Stoll, the District Risk Management Specialist, at 348-6113 to file a First Report of Injury today.

SUPERVISOR'S SECTION: The supervisor who is notified of the employee's work injury must complete this portion of the accident report.

Did the Accident/Injury occur due to: ☐ Failure to obey rules ☐ Intoxication ☐ Failure to use safety devices ☐ Not applicable

If NOT APPLICABLE, please explain why not._____

Was accident/injury investigated? ☐ Yes ☐ No If YES, name of investigator:_____

Was employee using protective equipment, devices or following safety procedures or established / trained protocols? ☐ Yes ☐ No
If YES, please identify._____

If NO, please explain why not._____

Is employee able to continue with his/her duties? ☐ Yes ☐ No
If NO, please explain why not._____

Supervisor's description of condition that led to the accident/injury (environmental, tools/equipment, task being performed)._____

Supervisor's recommendations for preventing future accidents/injuries._____

SIGNATURE OF SUPERVISOR:_____ DATE:_____

Supervisors – please be aware of the following.

1. *Instruct employee to call Pam Stoll, District Risk Management Specialist, at 348-6113 to file a First Report of Injury EVEN IF NO MEDICAL TREATMENT IS REQUESTED.*
2. *Instruct employee to call Pam Stoll, District Risk Management Specialist, at 348-6113 if medical attention is needed – EMPLOYEE MUST SEE OUR WORK COMP PHYSICIAN AND NOT THEIR PERSONAL PHYSICIAN.*
3. *Instruct employee to complete the form containing the employee's choice of medical provider. This form should be faxed to Pam Stoll, Risk Management Specialist, at 348-6034 ON THE SAME DAY OF THE REPORT OF INJURY.*
4. *Please note that if an employee does not use our designated health care provider for work related injuries, the employee will be responsible for all medical costs incurred. Our regular health insurance WILL NOT provide benefits for work related injuries or accidents.*
5. *In an emergency, employees should be sent to the Emergency Room at North Colorado Medical Center, 1801 16th Street. The supervisor should then notify Pam Stoll, District Risk Management Specialist, IMMEDIATELY at 348-6113 to report the injury.*