Weld County School District 6
1025 Ninth Avenue
Greeley, Colorado 80631
970-348-6100
970-348-6034 fax
970-348-6000 | www.greeleyschools.org

EMPLOYEE CHOICE OF DESIGNATED WORK COMP MEDICAL PROVIDER

Complete this form even if you are not seeking medical treatment.

NAME OF INJURED WORKER:____

Print Complete Name

BUILDING/WORK SITE LOCATION:__________________________**DATE OF INJURY:**__________

You reported a work-related injury to the Risk Management office or to your supervisor at Weld County School District 6. To make sure you receive the care you need, we are filing a claim with our workers' compensation insurance carrier, Pinnacol Assurance. Pinnacol will contact you with your claim number and additional information. I am providing you with the list of medical providers we have selected to treat our injured employees. These medical providers specialize in on-the-job injuries and I want you to have the best possible care.

Please INITIAL and CHECK the box next to the provider of your choice.

______☐ Workwell Occupational Medicine, Greeley
Dr. Lloyd Luke
2528 W 16th Street
Greeley, CO 80634 Phone: 970-356-9800

______☐ Banner Occupational Health - Greeley
Dr. Marc Chimonas
1517 16th Ave Ct.
Greeley, CO 80631 Phone: 970-810-6810

______☐ Banner Occupational Health - Greeley
Dr. Daniel Bates
1517 16th Ave Ct
Greeley, CO 80631 Phone: 970-810-6810

______☐ Workwell Occupational Medicine, Loveland
Dr. Robert Dupper
1608 Topaz Dr.
Loveland, CO 80537 Phone: 970-593-0125

- **The District's authorized representative for reporting a work-related injury is:**
  Pam Stoll, Risk Management Specialist — Phone: 970-348-6113
  Administration Building, 3rd floor — Cell: 970-590-2357
  1025 9th Avenue, Greeley, CO 80631 — Fax: 970-348-6034

- **The District's authorized workers' compensation insurance carrier and contact is:**
  Laura Harrington, Claims Rep — Phone: 877-361-4300
  Pinnacol Assurance — Fax: 888-329-2208
  7501 E. Lowry Blvd
  Denver, CO 80230

I certify by my signature and the date noted below that I have received and have read this letter containing the information of the medical providers available to me in accordance to Colorado WC law. I have also initialed and checked the box next to the designated medical provider of my choice.

____ Date:______________

Signature of Injured Employee

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Print Name of Injured Employee

Fax this to 970-348-6034 *ON THE SAME DAY* of reporting your injury to Pam Stoll, District Risk Management Specialist