Instructions for Completing the

First Report of Injury

Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will *not* be able to save the form onto your computer's hard drive.

When you open the form, click in the "Employee's Name" box (field), complete the information, and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you *cannot* continue to type information into a field if it doesn't fit into the space provided.

Use numbers *only* to fill in the fields for Social Security #, phone numbers and dollar amounts. If a dollar amount contains cents, *do* type the period. To fill in a check box, click inside the box with your mouse. Some check boxes require you to select only one answer; you cannot check both. The "Injury Description", "Name of Witness", and "Name of Doctor" fields have a gray border to indicate how many lines you have to type in. Use the tab key to navigate to the next field.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To change the information in one field, use the backspace or delete key.

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See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Clear Entire Form

EMPLOYER'S FIRST REPORT OF INJURY

Employee's name (first, middle, last) | Social Security # | Male / Female | Employee's home phone # ( ) | OSHA Log #

Employee's street address | City | State | Zip code

Birth date / / | Marital status: Married, Single, Unknown | ...nt status: Part time, Other, Unknown | For Division use only

"Clear Entire Form" button
Clears all information at once

Employer's name | Federal ID # | Employer's phone # ( ) | SOI

Employer's mailing address | State | Zip code | POB

"Check Box"
Click in box

Average weekly wage at time of injury $ (see instructions on reverse side) | Check box if employee receives: Tips, Meals, Room, Health insurance | Check if these benefits are included in AWW: Tips, Meals, Room, Health insurance | NOI | Coder

Is the employer self-insured? Yes No | Were full wages paid for the DOI? Yes No | Are wages continued per C.R.S. 8-42-124?[1] Yes No

Injury/Illness date / / (See instructions | Time employee began work a.m. p.m. | Injury time a.m. p.m. | Last day worked / / | Date employer notified / / | Date disability began / / | Date returned to work / /

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"**Check Boxes with one selection**"
Check only one

Average weekly wage at time of injury $ (see instructions on reverse side)

Check box if employee receives: Tips, Meals, Room, Health insurance

Check if these benefits are included in AWW: Tips, Meals, Room, Health insurance

NOI

Coder

Is the employer self-insured? Yes No

Were full wages paid for the DOI? Yes No

Are wages continued per C.R.S. 8-42-124? [1] Yes No

Injury/Illness date | Time employee began work | Injury time | Last day worked | Date employer notified / / | Date disability began / / | Date returned to work / /

"**Gray Border**"
Enter information and tab to next field

Did injury cause death? Yes No

If so, date of death / /

Name, relationship, and address of closest dependent if injury caused death

Injury occurred because of: Intoxication, Safety violation, Not applicable

Tell us the part of body that was affected

Tell us the nature of the injury/illness[2]

What was the employee doing just before the accident occurred?[3]

Tell us how the injury occurred[4]

What object or substance directly harmed the employee?[5]

Did injury occur on premises? Yes No

Injury site address/ 9-digit zip code

Initial treatment (check one): None, Emergency room

Was the employee hospitalized overnight as an in-patient? Yes No

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See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY

Employee's name (first, middle, last)	Social Security #	☐ Male ☐ Female	Employee's home phone # ( )	OSHA Log #
Employee's street address	City	State	Zip code	
Birth date / /	Marital status ☐ Married ☐ Separated ☐ Single ☐ Unknown	Date of hire / /	Occupation	Employment status ☐ Full time ☐ Part time ☐ Other ☐ Unknown
Employer's name	Employer's Federal ID #	Employer's phone # ( )		
Employer's mailing address	City	State	Zip code	
Average weekly wage at time of injury $ (see instructions on reverse side)	Check box if employee receives ☐ Tips ☐ Meals ☐ Room ☐ Health insurance	Check if these benefits are included in AWW ☐ Tips ☐ Meals ☐ Room ☐ Health insurance		

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SOI
POB
NOI
Coder

Is the employer self-insured? ☐ Yes ☐ No	Were full wages paid for the DOI? ☐ Yes ☐ No	Are wages continued per C.R.S. 8-42-124? [1] ☐ Yes ☐ No

Injury/Illness date / / (See instructions on reverse side)	Time employee began work ☐ a.m. ☐ p.m.	Injury time ☐ a.m. ☐ p.m. ☐ unknown	Last day worked / /	Date employer notified / /	Date disability began / /	Date returned to work / /

Did injury cause death? ☐ Yes ☐ No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death	Injury occurred because of ☐ Intoxication ☐ Safety violation ☐ Not applicable

Tell us the part of body that was affected

Tell us the nature of the injury/illness[2]

What was the employee doing just before the accident occurred?[3]

Tell us how the injury occurred[4]

What object or substance directly harmed the employee? [5]

Did injury occur on premises? ☐ Yes ☐ No	Injury site address/ 9-digit zip code	Initial treatment (check one) ☐ None ☐ Emergency room ☐ Minor on-site ☐ Hospital >24 hrs ☐ Clinic/hospital	Was the employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Names of witnesses

Name of employer representative notified

Name and address of treating doctor or other health care professional

Name and address of facility where treated

Completed by (name)	Title	Phone # ( )	Date completed / /

The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.

Name of insurance company	Address
Name of third party administrator (if applicable)	Address
Adjuster name	Adjuster phone #

Policy #	Carrier claim #	Date insurer received first report / /	Block #	Adj. Code

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INSTRUCTIONS

This form contains all items requested on OSHA Form No. 301, "Injuries & Illnesses Incident Report"

General

- All injuries no matter how trivial must be reported to your insurance company.
- All injuries or occupational diseases which result in lost time from work in excess of three shifts or calendar days, or in permanent physical impairment, must be reported to your insurance carrier on this form within ten days after notice or knowledge of the injury or disease. Fatalities must be reported to your insurance carrier immediately.
- Forms should be typed or printed legibly.
- All questions must be answered completely to meet requirements of the Colorado Workers' Compensation Act and to conform to the OSHA requirements for Form No. 301.
- The employer has the right in the first instance, to select the physician who attends the injured employee.

Calculation of Average Weekly Wage

- Determine the weekly wage rate.
- Add the average weekly amount of any overtime wages, tips or commissions.
- Add the average weekly value of any board, rent, housing, or lodging provided by the employer *if the employer will not be paying such benefit during the period of disability.*
- If the employee is covered by group health insurance *and* the employer does not continue the employee's health insurance coverage during the period of disability, add the employee's cost of conversion to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Compute the total from the above categories and insert in the *Average weekly wage at time of injury* field.

Injury Date Information

In the case of an occupational disease, use the date of the last injurious exposure.

Notes

Are Wages continued per C.R.S. 8-42-124?[1]
(Subject to application with and approval of the Director of the Colorado Division of Workers' Compensation)

1 Any employer who, by separate agreement, working agreement, contract of hire, or any other procedure, continues to pay a sum in excess of the temporary total disability benefits to an employee temporarily disabled as a result of a work related injury or disease, and has not charged the employee with any earned vacation leave, sick leave, or other similar benefits, shall be reimbursed if insured by an insurance carrier or shall take credit if self-insured, to the extent of all moneys that such employee may be eligible to receive as compensation for temporary partial or temporary total disability subject to the approval of the Director of the Colorado Division of Workers' Compensation.

Injury Description (Tell us the part of body that was affected. Tell us the nature of the injury/illness [2]; What was the employee doing just before the accident occurred? [3]; What happened? [4]; What object or substance directly harmed the employee?[5])

2 Be more specific than ""hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
3 Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."
4 Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
5 Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank

Notices

You are hereby notified that if a child support obligation is owed, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S. YOU ARE FURTHER NOTIFIED that you must provide written notice of any award for social security, pension, disability or other source of income that might reduce your compensation benefits. This notice must be sent to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in suspension of your benefits pursuant to section 8-42-113.5, C.R.S.

C.R.S. Section 10-1-128(6) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes of defrauding or attempting to defraud 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."

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