Instructions for Completing the

First Report of Injury

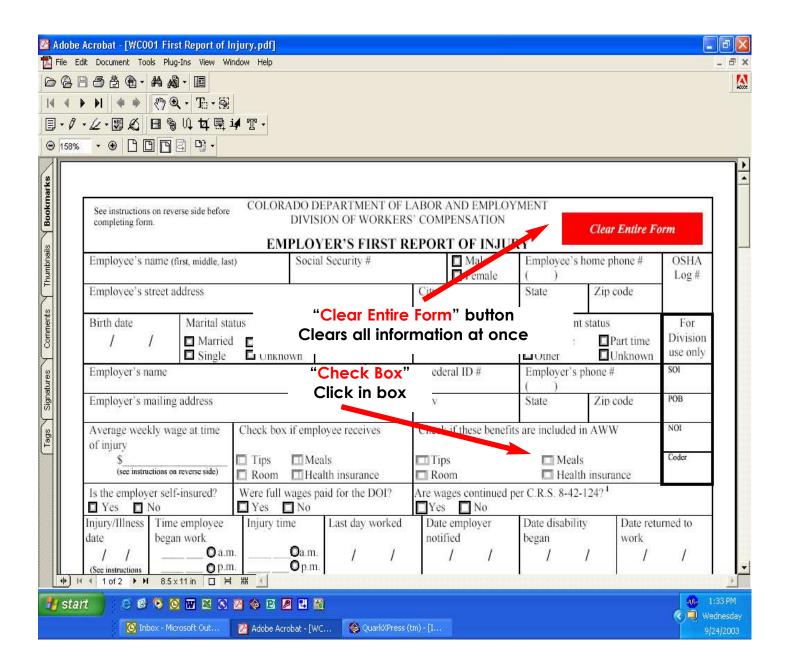
Please read all pages

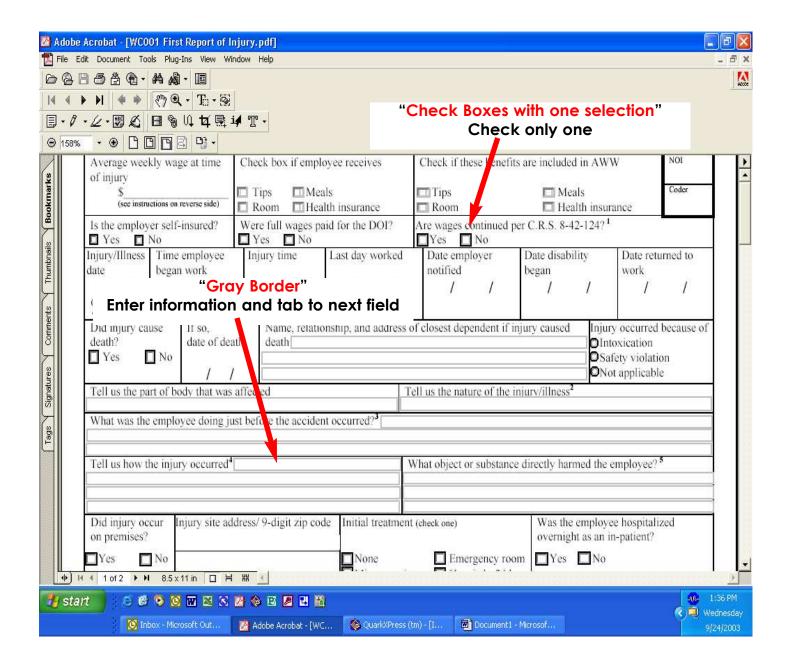
This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will <u>not</u> be able to save the form onto your computer's hard drive.

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 <u>Enter</u> key; pressing the <u>Enter</u> key will only page down. Each field has been *limited*. This means that you <u>cannot</u> continue to type information into a field if it doesn't fit into the space provided.

Use numbers <u>only</u> to fill in the fields for Social Security #, phone numbers and dollar amounts. If a dollar amount contains cents, <u>do</u> type the period. To fill in a <u>check box</u>, click inside the box with your mouse. Some <u>check boxes</u> 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.





See instructions on reverse side be completing form.	iore	DEPARTMENT SION OF WORI				MENT				
EMPLOYER'S FIRST REPORT OF INJURY										
Employee's name (first, middle, last) Social Security #							e's home phone #		OSHA Log#	
Employee's street address				City		State Zip code				
Birth date Marital status Date of hire				Occupation Employment status I					For	
· _	/ / Married Separated / Single Unknown		′ /			Full time			Division use only	
				yer's Federal ID # Employer's					SOI	
Employer's mailing address				City State			Zip c	code	POB	
Average weekly wage at time of injury Check box if employee receives				Check if these benefits are included in AWW NO.					NOI	
\$ □ Tips □ Meals				☐ Tips ☐ Meals			_		Coder	
(see instructions on reverse side) Room Health insurance				☐ Room ☐ Health insurance						
Is the employer self-insured? Were full wages paid for the DOI? Are wages continued per C.R.S. 8-42-124? Yes No Yes No										
ijury/Illness Time employee Injury time Last day work began work			ked	Date employer Date disabili notified began			ity	Date returned to work		
/ /	a.m.		/	/	1			1		
on reverse side) unknown										
Did injury cause death? If so, date of death Name, relationship, and address death				Injury occurred occurse of injury occurred occurs of injury occurs occ					because of	
Yes No				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						
Ten as now the figure occurred what object of substance directly narmed the employee:										
			_							
Did injury occur Injury site address/ 9-digit zip code Initial treatme				ent (check one) Was the employee hospitalized						
on premises?				overnight as an in-patient?						
Yes No None					Emergency room Yes No					
Minor on-site Hospital >24 hrs Clinic/hospital										
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	Date completed		
					()			/	/	
The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.										
Name of insurance company			Ad	Address						
Name of third party administrator (if applicable)				Address						
Adjuster name				Adjuster phone #						
Policy #	Carrier claim #			Date insurer received first report			Block	# A	dj. Code	

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)

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/illness²; 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."
- 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."