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 #		For Division use only
Employer's mailing address	City	State	Zip code	SOI
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		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