Delta County Joint School District

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

This form must be filled out when an employee is injured while in the course of employment. The employee shall complete this accident report within FOUR WORKING DAYS after suffering a work-related injury. Send this form to Rhonda Vincent, ADMIN BLDG.

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/ACCIDENT INFORMATION:
Date of Injury/Accident:_____ **Time of Injury/Accident**_____ **(AM or PM)**
LOCATION of Injury/Accident :_____

Did you miss any time from work because of the Injury/Accident? □ **YES** □ **NO**
If YES, date of last day worked: _____ **No. of Hrs off work:**_____ **Date you returned to work:**____

Please explain step-by-step how the accident occurred:_____

Please identify possible causes for the accident and if/how it might have been avoided :_____

Please describe the injury and include detail concerning the specific body part(s) affected, i.e. right or left, etc.: __

Name and Work Phone 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.
Also call Rhonda Vincent at 970-874-4438 to file a First Report of Injury today.

Delta County School District 50 J- ***Management Accident Investigation Report***

□ **Injury- first aid only** □ **Injury – medical treatment** □ **Property Damage**
□ **Near miss – record only**

Injured employee: **Occupation:**
Supervisor: **Department:**
Date of Accident: **Time of accident:**
Location of accident: **Witnesses:**

SUMMARY: Describe the accident. Use photos or sketches if necessary.

ANALYSIS: Identify possible causes for the accident and if/how it could have been avoided.

RECOMMENDATIONS: Outline any possible corrective actions that may prevent similar accidents.

ACTIONS TAKEN: Describe measures taken by management to improve the system (training, equipment, changes in policy/procedures, etc.) and prevent occurrence of similar accidents. Please describe the action, date implemented and any notes.

SIGNATURE OF SUPERVISOR: _____ **DATE:** _____

I HEARBY ACKNOWLEDGE THAT I HAVE RECEIVED A LIST OF DESIGNATED PROVIDERS FOR MY WORK RELATED INJURY.

SIGNATURE _____
DATE: _____

Supervisors – please be aware of the following.

1. ***Instruct employee to call Rhonda Vincent at 970-874-4438 to file a First Report of Injury EVEN IF NO MEDICAL TREATMENT IS REQUESTED.***
2. ***Instruct employee to call Vincent at 970-874-4438 if medical attention is needed – EMPLOYEE MUST SEE OUR WORK COMP PHYSICIAN AND NOT THEIR PERSONAL PHYSICIAN.***
3. ***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.***
4. ***In an emergency, employees should be sent to the Emergency Room at Delta County Memorial Hospital, 1501 E 3rd Street, Delta, CO. The supervisor should then notify Rhonda Vincent IMMEDIATELY at 970-874-4438 to report the incident.***

Delta County Joint School District No. 50

Joint with Delta, Gunnison, Montrose and Mesa Counties

WORKERS' COMPENSATION
DESIGNATED MEDICAL PROVIDERS FOR WORK-RELATED INJURIES

All employees must obtain treatment of work-related injuries and illnesses from the following designated medical providers:

Surface Creek Family Practice
Dr. Pulsipher
233 Cottonwood St., Delta, CO 81416
874-0336
255 SW 8th Ave., Cedaredge, CO 81413
856-3146

Cedaredge Doctor's Office
Dr. Wade
255 S. Grand Mesa Dr., Cedaredge, CO 81413
856-4111

In the event of a life threatening or limb threating emergency, the employee will be sent to the emergency room at: **Delta County Memorial Hospital** (874-7681)
205 Staff Lane, Delta, CO 81416

If the employee goes to the emergency room for treatment, they must also go to a designated provider for follow up appointments.

If an employee is treated by an unauthorized medical provider, the employee will be responsible for payment of said treatment.

Please contact Rhonda Vincent at 970-874-4438, concerning all claims.

Workman's compensation insurance is through: Pinnacol Assurance
7501 E. Lowry Blvd.
Denver, CO 80230