



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:

Supervisor:

Date of Accident:

Location of accident:

Occupation:

Department:

Time 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

**DESIGNATED MEDICAL PROVIDERS
FOR WORK-RELATED INJURIES AND ILLNESSES**

March 2019

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

DCMH Family Medicine

555 Meeker St
Delta, CO 81416
970-874-5777

DCMH Urgent Care

155 Stafford Lane
Delta, CO 81416
970-874-7696

Cedar Point Health

255 S Grand Mesa Dr.
Cedaredge, CO 81413
970-856-4111

DCMH West Elk-Hotchkiss

230 E Hotchkiss Ave
Hotchkiss, CO 81419
970-872-1400

DCMH West Elk Walk in Clinic

218 Grand Ave
Paonia, CO 81428
970-527-2100

In the event of a life threatening or limb threatening emergency, the insured employee will be sent to the emergency room at: **Delta County Memorial Hospital** (874-75681) 205 Stafford Lane, Delta, CO 81416. Follow-up care must be provided by the medical provider designated above.

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: Pinnacle Assurance
7501 E Lowry Blvd.
Denver, CO 80230

