

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 #		<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee's home phone # ()		OSHA Log #	
Employee's street address				City		State		Zip code
Birth date / /	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Unknown		Date of hire / /		Occupation		Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Other <input type="checkbox"/> Unknown	For Division use only
Employer's name			Employer's Federal ID #		Employer's phone # ()		SOI	
Employer's mailing address				City		State	Zip code	POB
Average weekly wage at time of injury \$ _____ <small>(see instructions on reverse side)</small>		Check box if employee receives <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance		Check if these benefits are included in AWW <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance			NOI	Coder
Is the employer self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were full wages paid for the DOI? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are wages continued per C.R.S. 8-42-124? ¹ <input type="checkbox"/> Yes <input type="checkbox"/> No				
Injury/Illness date / / <small>(See instructions on reverse side)</small>	Time employee began work ____ a.m. ____ p.m.	Injury time ____ a.m. ____ p.m. <input type="checkbox"/> unknown	Last day worked / /		Date employer notified / /	Date disability began / /	Date returned to work / /	
Did injury cause death? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death				Injury occurred because of <input type="checkbox"/> Intoxication <input type="checkbox"/> Safety violation <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury site address/ 9-digit zip code		Initial treatment (check one) <input type="checkbox"/> None <input type="checkbox"/> Emergency room <input type="checkbox"/> Minor on-site <input type="checkbox"/> Hospital >24 hrs <input type="checkbox"/> Clinic/hospital			Was the employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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	