Go to Form

Instructions for Completing the

First Report of Injury

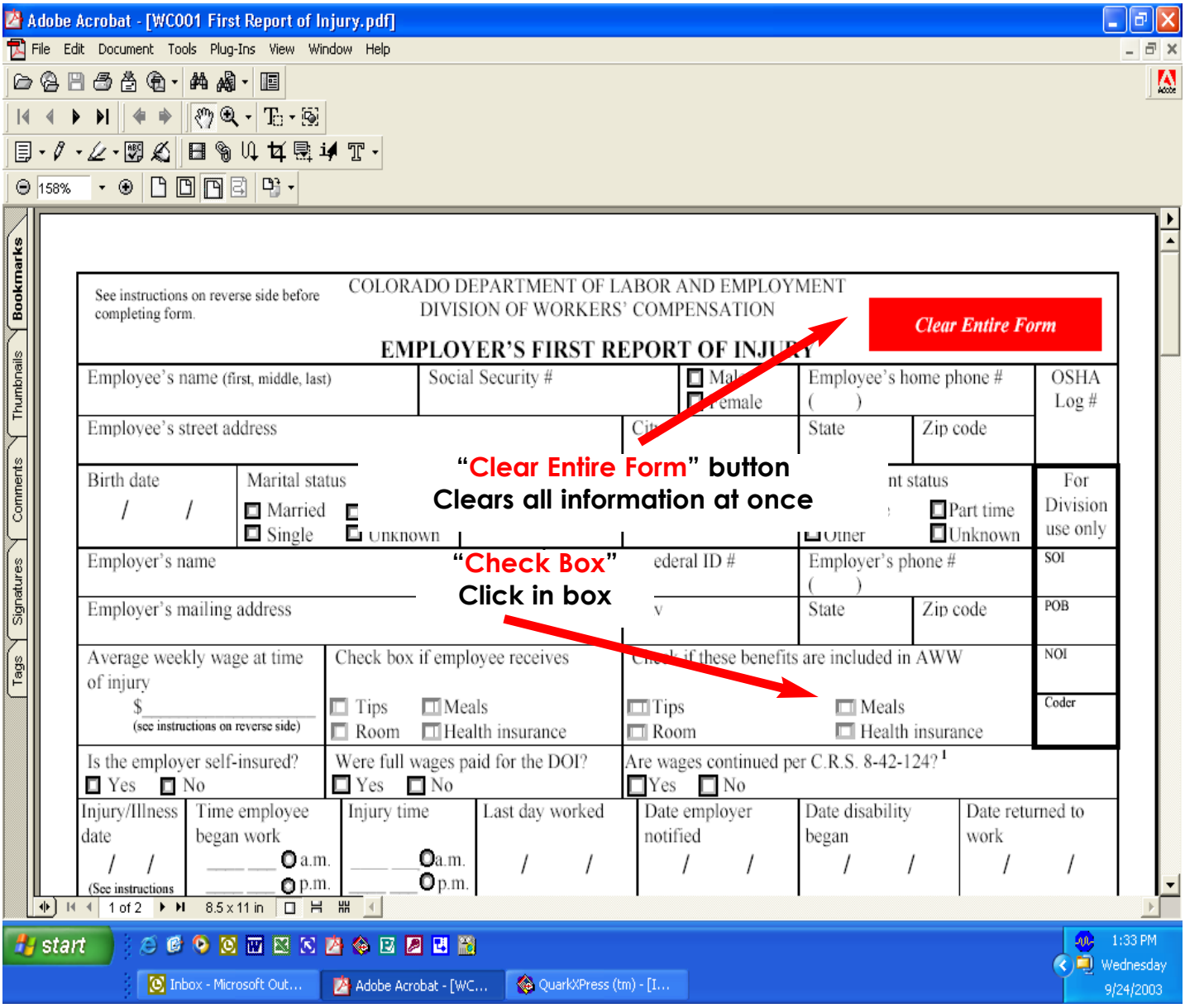
Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will *not* 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 Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you *cannot* continue to type information into a field if it doesn't fit into the space provided.

Use numbers *only* to fill in the fields for Social Security #, phone numbers and dollar amounts. If a dollar amount contains cents, *do* type the period. To fill in a check box, click inside the box with your mouse. Some check boxes 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.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Bookmarks
Thumbnails
Comments
Signatures
Tags
See instructions on reverse side before completing form.
COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
Clear Entire Form
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
State
Zip code
Birth date
Marital status
Married
Single
Unknown
Part time
Unknown
For Division use only
Employer's name
Employer's phone #
SOI
Employer's mailing address
State
Zip code
POB
NOI
Coder
Average weekly wage at time of injury
$
(see instructions on reverse side)
Check box if employee receives
Tips
Meals
Room
Health insurance
Tips
Meals
Room
Health insurance
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?
Yes
No
Injury/Illness date
(See instructions
Time employee began work
a.m.
p.m.
Injury time
a.m.
p.m.
Last day worked
Date employer notified
Date disability began
Date returned to work
1 of 2
8.5 x 11 in
"Clear Entire Form" button
Clears all information at once
"Check Box"
Click in box
start
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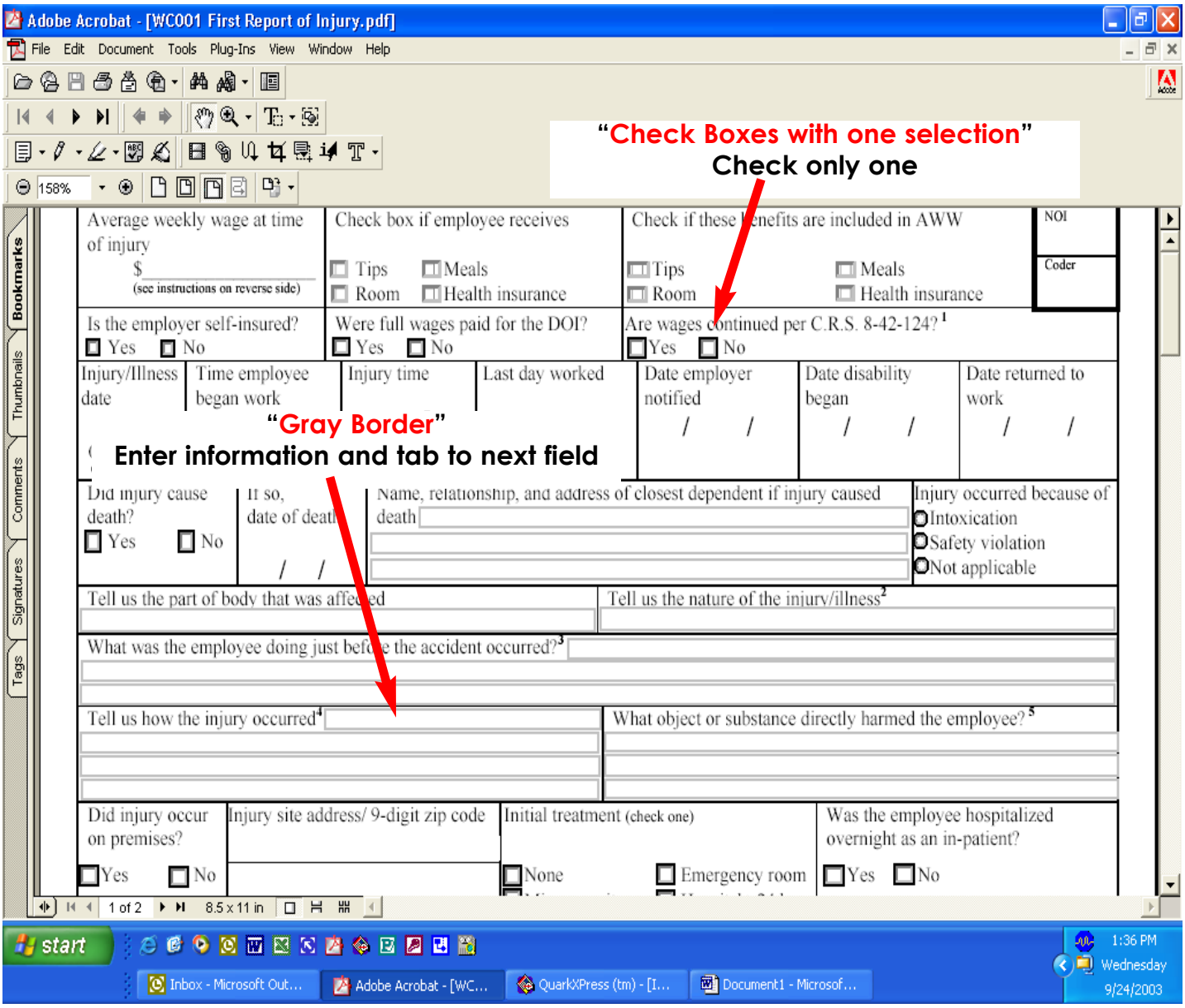
Wednesday
9/24/2003


Adobe Acrobat - [WC001 First Report of Injury.pdf]
File Edit Document Tools Plug-Ins View Window Help
"Check Boxes with one selection"
Check only one
"Gray Border"
Enter information and tab to next field
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
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
Time employee began work
Injury time
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
Was the employee hospitalized overnight as an in-patient?
Yes No
Bookmarks
Thumbnails
Comments
Signatures
Tags
1 of 2
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start
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Wednesday
9/24/2003

See instructions on reverse side before completing form.

Back to Instructions

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Clear Entire Form

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	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 $_____ (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	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 ☐ Minor on-site ☐ Clinic/hospital ☐ Emergency room ☐ Hospital >24 hrs	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

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)

1 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/illness [2]; 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."
3 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."

THE EMPLOYER IS REQUIRED BY LAW TO POST THIS NOTICE

Colorado Employment Security Act (CESA), 8-74-101(2); Regulations Concerning Employment Security 7.3.1 through 7.3.5

NOTICE TO WORKERS

You have the right to be properly classified as an employee if you meet the criteria in Colorado Revised Statute 8-70-115. If you believe you have been improperly classified as an independent contractor, there is a complaint process available to you. On the first offense, an employer may be fined up to $5,000 per misclassified employee. To file a complaint, call the Unemployment Insurance Audit section at 303-318-9100 and select Option **3**, or visit www.colorado.gov/cdle/ui.

You, as an employee, are entitled to unemployment insurance benefits if you become unemployed through no fault of your own. Your employer contributes to unemployment insurance and cannot deduct this from your wages.

If you become unemployed and wish to file for unemployment insurance benefits, go to www.colorado.gov/cdle/ui and click on File for Unemployment. You may also call one of the following numbers instead:

303-318-9000
(Denver-metro area)

1-800-388-5515
(Outside Denver-metro area)

TDD 303-318-9016
(Hearing Impaired Denver-metro area)

TDD 1-800-894-7730
(Hearing Impaired Outside Denver-metro area)

If your hours of work and pay are reduced, you may be entitled to partial unemployment benefits.

IMPORTANT NOTICE: Be sure to have your social security number and the name and address of your last employer available when you call to file a claim for unemployment insurance benefits.

AVISO PARA EMPLEADOS

Usted tiene el derecho de ser propiamente clasificado como un empleado si se cumplen los criterios en Estatuto Revisado de Colorado 8-70-115. Si cree que ha sido impropiamente clasificado como un contratista independiente, hay un proceso de queja disponible. Por la primera ofensa, un empleador puede ser multado hasta $5,000 por cada empleado misclasificado. Para presentar una queja, llame a la sección de Auditoría de Seguro de Desempleo al 303-318-9100, y marque Opción **3** o visite www.colorado.gov/cdle/ui.

Usted, como empleado, tiene derecho a los beneficios de seguro de desempleo si se encuentra desempleado y no es responsable por la separación. La compañía contribuye al seguro de desempleo y no puede deducirlos de su sueldo.

Si se encuentra desempleado y desea reclamar los beneficios de seguro de desempleo, vaya al sitio www.colorado.gov/cdle/ui y haga click en en enlace File for Unemployment. Támbien puede llamar a los números siguentes.

303-318-9333
(Área metropolitana de Denver)

1-866-422-0402
(Fuera del área metropolitana de Denver)

TDD 303-318-9016
(Impedimento Auditivo Área de Denver)

TDD 1-800-894-7730
(Impedimento Auditivo Fuera del área metropolitana de Denver)

Si sus horas de trabajo y pago son reducidas, usted puede tener derecho a los beneficios parciales de seguro de desempleo.

AVISO IMPORTANTE: Asegúrese de tener su número de seguro social y el nombre y la dirección de su empleo mas reciente cuando llame para establecer su reclamo de seguro de desempleo.

Employers can download copies of this poster at www.colorado.gov/cdle/ui, click on **Forms & Publications**, and then click on **Employer Forms**.

Additional copies can be requested by contacting the Colorado Department of Labor and Employment, Unemployment Insurance Program, P.O. Box 8789, Denver, Colorado 80201-8789 or by calling 303-318-9100 or 1-800-480-8299

WARNING

IF YOU ARE INJURED ON THE JOB, WRITTEN NOTICE OF YOUR INJURY MUST BE GIVEN TO YOUR EMPLOYER WITHIN FOUR WORKING DAYS AFTER THE ACCIDENT, PURSUANT TO SECTION 8-43-102(1) AND (1.5), COLORADO REVISED STATUTES.

IF THE INJURY RESULTS FROM YOUR USE OF ALCOHOL OR CONTROLLED SUBSTANCES, YOUR WORKERS' COMPENSATION DISABILITY BENEFITS MAY BE REDUCED BY ONE-HALF IN ACCORDANCE WITH SECTION 8-42-112.5, COLORADO REVISED STATUTES.

AVISO

SI SE LASTIMA EN EL TRABAJO, DEBE DARLE UN AVISO POR ESCRITO A SU EMPLEADOR DENTRO DE CUATRO DÍAS LABORABLES DEL ACCIDENTE, SEGÚN A LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-43-102(1) Y (1.5).

SI EL ACCIDENTE RESULTA DEBIDO AL USO DE ALCOHOL O UNA SUSTANCIA CONTROLADA, SUS BENEFICIOS DE LA INCAPACIDAD DE LA COMPENSACIÓN DE LOS TRABAJADORES PUEDEN SER REDUCIDOS POR UN MEDIO EN ACUERDO DE LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-42-112.5.