See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY

NCCI Code 8810
Cost Center Code
010010002

Employee's name (first, middle, last) **John M Smith**	Social Security # 111-22-3333	x Male ☐ Female	Employee's home phone # (303) 555-5555	OSHA Log #
Employee's street address 123 Main St.	City Anytown	State CO	Zip code 80203	
Birth date **9/ 16 /53**	Marital status x Married ☐ Separated ☐ Single ☐ Unknown	Date of hire **6/ 02 /86**	Occupation **Park Maintenance**	Employment status x Full time ☐ Part time ☐ Other ☐ Unknown
Employer's name XYZ District	Employer's Federal ID # 84-00002222	Employer's phone # (970)555-1215		
Employer's mailing address XSY Streeet	City Anytown	State CO	Zip code 80203	
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		
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		

For Division use only: SOI | POB | NOI | Coder

Injury/Illness date	Time employee began work	Injury time	Last day worked	Date employer notified	Date disability began	Date returned to work
2/15 /98 (See instructions on reverse side)	____ ___ ☐ a.m. ____ ___ ☐ p.m.	____ ___ ☐ a.m. ____ ___ ☐ p.m. ☐ unknown	**2/ 15 /98**	**2/ 15 /98**	/ /	**2/15 /98**

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

Sample

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 **Colorado Special Districts Property & Liability Pool**	Address **c/o TRISTAR Risk Management**
Name of third party administrator (if applicable)	Address **P.O. Box 2805, Clinton, IA 52733-2805**
Adjuster name	Adjuster phone #**(800) 318-8870 Ext. 1**

Policy # **CSD Pool**	Carrier claim #	Date insurer received first report / /	Block # **806**	Adj. Code