See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

NCCI Code 8810
Cost Center Code 010010002

EMPLOYER'S FIRST REPORT OF INJURY

Employee's name (first, middle, last)	Social Security #	Sex	Employee's home phone #	OSHA Log #
John M Smith	111-22-3333	x Male ☐ Female	(303) 555-5555	

Employee's street address	City	State	Zip code
123 Main St.	Anytown	CO	80203

Birth date	Marital status	Date of hire	Occupation	Employment status	For Division use only
9/ 16 /53	x Married ☐ Separated ☐ Single ☐ Unknown	6/ 02 /86	**Park Maintenance**	x Full time ☐ Part time ☐ Other ☐ Unknown	

Employer's name	Employer's Federal ID #	Employer's phone #	SOI
XYZ District	84-00002222	(970)555-1215	

Employer's mailing address	City	State	Zip code	POB
XSY Street	Anytown	CO	80203	

Average weekly wage at time of injury	Check box if employee receives	Check if these benefits are included in AWW	NOI / Coder
$__________ (see instructions on reverse side)	☐ Tips ☐ Meals ☐ Room ☐ Health insurance	☐ Tips ☐ Meals ☐ Room ☐ Health insurance	

Is the employer self-insured?	Were full wages paid for the DOI?	Are wages continued per C.R.S. 8-42-124? [1]
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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? ✓	If so, date of death	Name, relationship, and address of closest dependent if injury caused death	Injury occurred because of
☐ Yes ☐ No	/ /		☐ 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?	Injury site address/ 9-digit zip code	Initial treatment (check one) ✓	Was the employee hospitalized overnight as an in-patient? ✓
☐ Yes ☐ No ✓	✓	☐ None ☐ Emergency room ☐ Minor on-site ☐ Hospital >24 hrs ☐ Clinic/hospital	☐ 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
Colorado Special Districts Property & Liability Pool	**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