FIRST REPORT OF INJURY FORM

STATE OF COLORADO MILITARY & VETERANS AFFAIRS

BROADSPIRE®
a Crawford Company

Complete yellow shaded areas and e-mail to tamy.calahan@dmva.state.co.us or Fax to 720-250-1529

* REPORTED BY PERSON'S NAME:	Tamy Calahan						
* TITLE:	Human Resource Director		* BUSINESS PHONE:	720-250-1520		EXT:	
FAX NUMBER:	720-250-1529		E-MAIL ADDRESS:	tamy.calahan@dmva.state.co.us			
* DATE OF ACCIDENT: MM/DD/YYYY			* TIME OF ACCIDENT: (HH:MM AM/PM)				
A. LOSS LOCATION INFORMATION							
* DEPARTMENT NAME	DEPARTMENT OF MILITARY AFFAIRS						
* ADDRESS:	6848 South Revere Parkway						
* CITY, STATE, ZIP:	Centennial, CO 80112			*COUNTY:	Arapahoe		
* BUSINESS PHONE:	720-250-1520	EXT.		FAX NUMBER:	720-250-1529		
* LOCATION CODE:		POLICY NUMBER:		NOT APPLICABLE - SELF INSURED CLIENT			
NATURE OF BUSINESS:	Military	UNEMPLOYMENT COMPENSATION #:					
* FEDERAL ID NUMBER:	84-0666739	SIC CODE:					
B. LOSS LOCATION INFORMATION							
* LOCATION NAME:							
* DID ACCIDENT OCCUR ON THE INSUREDS PREMISES? (X)	YES		NO				
* IF NO, ENTER PHYSICAL ADDRESS:							
* CITY, STATE, ZIP:		*COUNTY:					
C. INSURED CONTACT INFORMATION							
* WOULD YOU LIKE TO BE THE CONTACT PERSON?: (X)	YES		NO	X			
IF NO, ENTER CONTACT PERSON NAME:	Tamy Calahan		TITLE:	HR Director			
CONTACT PHONE:	720-250-1520	E-MAIL ADDRESS:		tamy.calahan@dmva.state.co.us			
D. EMPLOYEE INFORMATION							
*SOCIAL SECURITY NUMBER:		* EMPLOYEE NAME:					
* HOME ADDRESS:							
* CITY, STATE, ZIP:		COUNTY:					
RESIDENCE PHONE:		BUSINESS PHONE:		EXT:			
BIRTHDATE: MO/DAY/YR	* AGE:	* SEX: (X)	FEMALE		MALE		
NUMBER OF DEPENDENTS:	* MARITAL STATUS:						
* REGULAR OCCUPATION:	* REGULAR DEPARTMENT:	Military & Veterans Affairs	* CLASS CODE:				
DATE OF HIRE: MM/DD/YY	HIRE COUNTRY:	USA	HIRE STATE:	Colorado	STATE HIRE DATE: MM/DD/YY		
SUPERVISOR NAME:		SUPERVISOR PHONE #:					
EMPLOYMENT STATUS: (Full/Part Time)		* PAY TYPE: (Weekly, Bi-Weekly, etc.)					
* GROSS WAGES: (Based on Pay Type)							
HOURS WORKED PER DAY?	WORK SCHED. (T-TH, M-F, M-TH)?		HOURS PER WEEK?				
E. LOSS INFORMATION							
EMPLOYEE START TIME: (HH:MM AM/PM)		* DATE EMPLOYER NOTIFIED: (MM/DD/YY)					
* QUESTIONABLE CASE?	YES		NO				
* DESCRIPTION OF ACCIDENT:							

* REMOVED BY AMBULANCE? (X)	YES		NO		UNKNOWN		
* ANY STITCHES/SURGERY REQUIRED? (X)	YES		NO				
* WAS A FATALITY INVOLVED? (X)	YES		DATE		NO		
* DESCRIBE INJURY OR ILLNESS:							
* BODY PART INJURED?:		* INDICATE RIGHT/LEFT SIDE OF BODY:					
* WORK PROCESS INJURED WAS DOING?							
* DIRECT CAUSE: (X)	SPECIFIC INJURY:		OCCUPATIONAL DISEASE OR CUMULATIVE INJURY :				
SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?: (Y/N/U)		SAFEGUARDS OR SAFETY EQUIPMENT UTILIZED?: (Y/N/U)					
* EMPLOYEE ON RESTRICTED DUTY? (X)	YES		NO		UNKNOWN		
* FULL PAY FOR DAY OF INJURY?	YES		NO		UNKNOWN		
* ANY LOST TIME? (X)	YES		NO		UNDETERMINED		
LAST DAY WORKED: MM/DD/YY		START DATE OF DISABILITY:					
DATE RETURNED TO WORK: MM/DD/YY		EXPECTED RETURN TO WORK: MM/DD/YY					
* SALARY CONTINUED DURING DISABILITY?	YES		NO		UNKNOWN		

F. MEDICAL INFORMATION

* INITIAL TREATMENT? (X) ONLY SELECT ONE	* NO MEDICAL TREATMENT		* MINOR BY EMPLOYER	
	* MINOR HOSP/CLINIC		* EMERGENCY CARE	
	* HOSPITALIZED 24 HRS		* FUTURE MEDICAL/LOST TIME	
	* UNKNOWN			

PHYSICIAN/MINOR HOSPITAL CLINIC INFO.		HOSPITAL INFORMATION	
* NAME:		* NAME:	
ADDRESS:		ADDRESS:	
CITY, STATE, ZIP:		CITY, STATE, ZIP:	
BUSINESS PHONE:		BUSINESS PHONE:	

G. WITNESS INFORMATION

* NAME:		* NAME:	
ADDRESS:		ADDRESS:	
CITY, STATE, ZIP:		CITY, STATE, ZIP:	
PHONE:		PHONE:	

H. ADDITIONAL CONFIRMATION LETTERS (If different than local business address)

COMPANY NAME:	
ADDRESS:	
CITY, STATE, ZIP:	
FAX NUMBER:	

I. GENERAL LOSS INFORMATION

GENERAL REMARKS:	

PERSON COMPLETING FORM:		DATE:	