STATE OF COLORADO DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

FIRST REPORT OF INJURY

Employee's name (first, middle, last)	Social Security #	☐ Male ☐ Female	Employee's home phone # ( )
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

Employer's name: **DEPARTMENT OF MILITARY AND VETERANS AFFAIRS**	Workman Comp. Contact: **SAMANTHA JOHNSON** **Samantha.johnson@dmva.state.co.us**	Employer's phone # **(720)-250-1524**
Employer's mailing address: **6848 S. REVERE PARKWAY**	City: **CENTENNIAL**	State: **CO**	Zip code: **80112**

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[1]

What was the employee doing just before the accident occurred?[2]

Tell us how the injury occurred[3]	What object or substance directly harmed the employee? [4]

Did injury occur on premises? ☐ Yes ☐ No	Injury site address	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 Samantha Johnson
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 / /

Signature:

The following is to be completed by Human Resources.

Adjuster name	Adjuster Email

Worker's Comp Claim #	Date submitted to Origami	Name of Reporter:

Signature

INSTRUCTIONS

General

- Complete yellow shaded areas and email to Samantha.johnson@dmva.state.co.us or Fax to 720-250-1529
- All injuries no matter how trivial must be reported.
- 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. Fatalities must be report immediately.
- Forms should be typed or printed legibly.
- The employer has the right in the first instance, to select the physician who attends the injured employee.

Notes

Injury Description (Tell us the part of body that was affected. Tell us the nature of the injury/illness [1]; what was the employee doing just before the accident occurred?[2]; what happened? [3]; what object or substance directly harmed the employee? [4])

1. Be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
2. 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."
3. 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."
4. 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."