See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

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
Employer's name	Employer's Federal ID #	Employer's phone # ( )		
Employer's mailing address	City	State	Zip code	
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		

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SOI
POB
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
/ / (See instructions on reverse side)	____ ____ ○ a.m. ____ ____ ○ p.m.	____ ____ ○ a.m. ____ ____ ○ p.m. ○ unknown	/ /	/ /	/ /	/ /

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 ☐ 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		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."

See instructions on reverse side before completing form

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

WORKER'S CLAIM FOR COMPENSATION

Employee's name (first, middle, last)	Social Security #	☐ Male ☐ Female	Employee's home phone #	Division Use Only
Employee's street address	City	State	Zip code	SOI
Birth date / /	Marital status ☐ Married ☐ Separated ☐ Single ☐ Unknown	Dependents ☐ Yes ☐ No	Date of hire / /	Occupation
Employment status ☐ Full time ☐ Part time ☐ Other ☐ Unknown				POB
Employer's name (Company)			Employer's phone #	NOI
Employer's mailing address	City	State	Zip code	Coder

Average Weekly Wage

A. Calculate the *average weekly wage.* Multiply the average number of hours worked per week, excluding overtime, times the hourly wage—see instructions **Subtotal (A)** $ ________________

B. Check box if employee receives

	Will benefit continue during disability?		If benefit will not continue, provide the average weekly value of the benefit
☐ Overtime	☐ Yes	☐ No	$ ________________
☐ Tips (amount reported to IRS)	☐ Yes	☐ No	$ ________________
☐ Commissions	☐ Yes	☐ No	$ ________________
☐ Piecework	☐ Yes	☐ No	$ ________________
☐ Mileage (if a form of salary)	☐ Yes	☐ No	$ ________________
☐ Other (room, board, etc.)	☐ Yes	☐ No	$ ________________
☐ Health Insurance (see instructions)	☐ Yes	☐ No	$ ________________
		Subtotal (B)	$ ________________

C. **Add subtotals A & B** = **Average weekly wage at time of injury (C)** $ ________________

Date of injury/disease	Time employee began work	Injury time	Last date worked	Date employer notified	Date you returned to work	Do you claim to have a permanent disability?
/ / (See instructions)	____ ____ ☐ a.m ____ ____ ☐ p.m	____ ____ ☐ a.m. ____ ____ ☐ p.m ☐ Unknown	/ /	/ /	/ /	☐ Yes ☐ No ☐ Unknown

Which part of body was affected? (specify *upper* or *lower* for arms, legs and back injuries)	Tell us the nature of the injury/illness (sprain, strain, laceration, contusion, fracture, etc.) [1]
What were you doing just before the accident occurred? [2]	
How did the injury occur? [3]	
What object or substance directly harmed you? [4]	Name and phone number of witness
Where did the accident occur? (street address, city, state, and county)	To whom was it reported?
Initial treatment (check one) ☐ None ☐ Minor on-site ☐ Emergency room ☐ Clinic/Hospital ☐ Hospital stay over 24 hrs	Do you claim to have a disfigurement or scar? ☐ Yes ☐ No
Name and address of treating doctor or other health care professional	Name and address of facility where treated

If claim is for an occupational disease (i.e., asbestos related, repetitive motion, hearing loss), give names of employers where the exposure occurred and dates of employment (attach additional sheet if needed).

Employer	Dates of employment / / to / /
Employer	Dates of employment / / to / /

Completed by **Date completed** / /

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FEIN	Carrier claim #	
Policy #	Adjuster Code	Block #

CALCULATION OF AVERAGE WEEKLY WAGE

To determine the weekly wage calculate the following:

- First, calculate your average weekly wage. Multiply the average number of hours worked per week (excluding overtime) times your hourly wage. If you are paid by the month, multiply your monthly salary times 12 (months) and divide by 52 (weeks). If you are paid bi-weekly (every other week), take your bi-weekly salary and divide by 2. If you are paid on a per diem basis, multiply the daily wage times the number of days and fractions of days in the week you would have worked under the contract of hire if the injury had not occurred
- Next, determine the average weekly amount of any overtime, tips (as reported to the IRS), commissions, piecework (average weekly value can be calculated by taking the total amount earned with the employer in the 12 months immediately preceding the injury and dividing that amount by the number of weeks, and fractions of weeks worked). If mileage is a form of salary, take the average earned per week in the 60 days immediately preceding the injury.
- Add the average weekly value of any board, rent, housing or lodging, etc., provided by the employer *if the employer will not be paying such benefit during the period of disability.*
- If you are covered by group health insurance *and* your employer does not continue your health insurance coverage during the period of disability, add your cost of converting to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Add the totals from each of the above categories to obtain your average weekly wage and insert in *Average weekly wage at time of injury* field.

DATE OF INJURY/DISEASE

Always include a date of injury. In the case of an occupational disease, use the date you were last exposed to the hazard.

INJURY DESCRIPTION

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 you were 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, I fell 20 feet"; "I was sprayed with chlorine when gasket broke during replacement"; "I developed soreness in my wrist over time."
4 Examples: "concrete floor"; "chlorine"; "radial arm saw", "beryllium."

FILING AND BENEFIT INFORMATION

Upon completion, mail or deliver two (2) copies of the *Worker's Claim for Compensation* to: **The Colorado Division of Workers' Compensation, Customer Service Unit, 633 17th St., Suite 400, Denver, CO 80202-3626**. In order to obtain information on benefits and dispute resolution options, or to request a copy of the *Employee's Guide*, please contact our Customer Service Unit at (303) 318.8700 or toll free at (888) 390.7936 for English, or (800) 685.0891 for Spanish. You may also visit our website at www.coworkforce.com/DWC/

GENERAL INFORMATION

When your claim form is received by the Division of Workers' Compensation, a copy will be sent to your employer's insurance carrier (insurer). The insurer has 20 days from receipt of this information to advise, in writing, whether liability will be admitted or denied, that is, whether it accepts responsibility for payment of related medical and/or lost wage benefits. If the insurer fails to admit liability within the prescribed time limit, you will receive information from the Division on the options that are available to you.

Always notify your employer of an injury. Failure to report an injury to the employer in writing within 4 days could result in loss of one day's compensation for each day's failure to notify.

Seek medical assistance as soon as possible. The employer has the right to select the physician who attends you. If you fail to remain under the care of a physician designated by the employer or its insurer, you may be responsible for payment of any unauthorized medical expenses. If the employer fails to designate a physician, you have the right to select a treating physician.

If you would like to change physicians, you must first request in writing, from the insurer, permission to change physicians and receive authorization to do so. If such permission is neither granted nor refused within twenty days, the insurer shall be deemed to have waived any objection to the change.

Failure to attend medical appointments may result in the suspension of benefits by the insurer.

For additional information on the provisions of the Colorado workers' compensation system, you may contact the Customer Service Unit of the Colorado Division of Workers' Compensation at (303) 318.8700, or toll free at (888) 390.7936.

NOTICES

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COLORADO WORKERS' COMPENSATION

Supplemental Report of Return To Work

Workers' Compensation (WC) # ____________ Date of Injury ____________

Employee Name ____________ Carrier Claim # ____________

Social Security # ____________ Employer ____________

Purpose:
The purpose of this form is to provide information to determine the accurate payment of temporary disability benefits.

Instructions:

1. **This form may be completed by the employee or employer.**
2. **This form should be completed each time the employee returns to work at full or reduced wages.**
3. **This form should be forwarded to your workers' compensation carrier.**

1. Last day employee worked ____________
2. Date employee returned to work ____________
3. Employee's return-to-work-wages (Check the box that applies)

☐ Full Wages / Full Hours

☐ Reduced Wages (Provide wage information to the claims adjuster every 2 weeks during periods of wage loss)

☐ Full Wages / Reduced Hours (Provide wage information to the claims adjuster every 2 weeks during periods of wage loss)

Additional Information ____________

____

____

Completed by (Check the box that applies) ☐ Employee ☐ Employer

____________ ____________

Name Date

Address ____________

____

Phone # ____________

Fax # ____________

WC12 Rev 11/17