

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) <b>John M Smith</b>		Social Security # 111-22-3333		<input checked="" type="checkbox"/> Male <input type="checkbox"/> 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 <b>9/ 16 /53</b>		Marital status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Unknown		Date of hire <b>6/ 02 /86</b>		Occupation <b>Building Supervisor</b>		Employment status <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
Employer's name XYZ District				Employer's Federal ID # 84-00002222		Employer's phone # ( 970 )555-1215		SOI		
Employer's mailing address XSY Street				City Anytown		State CO		Zip code 80203		
Average weekly wage at time of injury \$ _____ <small>(see instructions on reverse side)</small>		Check box if employee receives <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance			Check if these benefits are included in AWW <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance				For Division use only NOI Coder	
Is the employer self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were full wages paid for the DOI? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are wages continued per C.R.S. 8-42-124? <sup>1</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No					
Injury/Illness date <b>2/15 /98</b> <small>(See instructions on reverse side)</small>	Time employee began work _____ <input type="checkbox"/> a.m. _____ <input type="checkbox"/> p.m.	Injury time _____ <input type="checkbox"/> a.m. _____ <input type="checkbox"/> p.m. <input type="checkbox"/> unknown	Last day worked <b>2/ 15 /98</b>		Date employer notified <b>2/ 15 /98</b>	Date disability began / /		Date returned to work <b>2/15 /98</b>		
Did injury cause death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death <b>Sample</b>					Injury occurred because of <input type="checkbox"/> Intoxication <input type="checkbox"/> Safety violation <input type="checkbox"/> Not applicable			
Tell us the part of body that was affected <sup>✓</sup>				Tell us the nature of the injury/illness <sup>2</sup> ✓						
What was the employee doing just before the accident occurred? <sup>3</sup> ✓										
Tell us how the injury occurred <sup>4</sup> ✓					What object or substance directly harmed the employee? <sup>5</sup> ✓					
Did injury occur on premises? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Injury site address/ 9-digit zip code ✓		Initial treatment (check one) <input checked="" type="checkbox"/> None <input type="checkbox"/> Emergency room <input type="checkbox"/> Minor on-site <input type="checkbox"/> Hospital >24 hrs <input type="checkbox"/> Clinic/hospital			Was the employee hospitalized overnight as an in-patient? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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 ✓/ /			
<b>The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.</b>										
Name of insurance company <b>Colorado Special Districts Property &amp; Liability Pool</b>					Address <b>c/o County Technical Services, Inc.</b>					
Name of third party administrator (if applicable)					Address <b>800 Grant St., Suite 400, Denver, CO 80203</b>					
Adjuster name					Adjuster phone #(888) 559-6829 (303) 861-0507					
Policy # <b>CSDP</b>		Carrier claim #		Date insurer received first report / /		Block # <b>806</b>		Adj. Code <b>CY</b>		