Important: Please fax this report to HR (303) 438-6328 within 24 hours of injury

CITY AND COUNTY OF BROOMFIELD
FIRST REPORT OF INJURY

EMPLOYEE (INJURED WORKER) INFORMATION:

Name (First, Middle Initial, Last):

Home Address (Street; City; State; Zip Code):

Home Phone: ☐ Male ☐ Female Marital Status: Date of Birth:

MEDICAL PROVIDER INFORMATION:

Effective 01/01/2008: Injured Worker has the choice of the following 2 designated medical providers for primary care:

Date of First Visit **Medical Facility Used**

Arbor Occupational Medicine; 290 Nickel Street, Suite 200; Broomfield, CO 80020 Phone: 303-460-9339

OR

HealthONE Occupational Medicine; 9195 Grant St, Suite 100; Thornton, CO 80229 Phone: 303-292-0034

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AFTER HOURS/EMERGENCY CARE:

Rocky Mountain Urgent Care; 6080 W 92nd Ave.; Westminster, CO 80031 Phone: 303-429-9311

Avista Hospital; 100 Health Park Drive; Louisville, CO 80027 Phone: 303-673-1111

Other (Please indicate name of facility/address/phone #):

Medical Treatment Refused: ☐ Yes ☐ No Treated by Employer: ☐ Yes ☐ No 911 Called: ☐ Yes ☐ No

Hospitalized more than 24 hrs/Overnight: ☐ Yes ☐ No

ACCIDENT INFORMATION:

Lost Time Claim? ☐ Yes ☐ No (Did employee miss more than 3 scheduled working days due to this work-related injury?)

Average Working Hours Scheduled Per Week: Number of Days Worked Per Week:

Hours Worked Per Day: Returned to Work? ☐ Yes ☐ No

Date Returned: - OR - Estimated Date of Return:

Address Where Accident Occurred (Street, City, State, Zip Code):

Date Of Injury: Time of Injury: ☐ AM ☐ PM Time Work Began: ☐ AM ☐ PM

Last Day Worked: Date Employer Notified:

Name Of Employer Representative Notified: Phone:

What Equipment was being used?

Specific activity in which employee was engaged (What were you doing?):

Part(s) of Body Injured:

(PLEASE COMPLETE ADDITIONAL INFORMATION ON PAGE 2)

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How Did Accident/Injury Occur? (Please Note: The information provided will be available to Pinnacol.)

Was Intoxication Involved? ☐ Yes ☐ No

Were Safeguards/Safety Equipment Provided? ☐ Yes ☐ No Used? ☐ Yes ☐ No

Witness(es): Phone:

Witness(es): Phone:

Witness(es): Phone:

This form is completed by: Phone Number: Date:

I have received a copy of the letter regarding my choice for treatment from 1 of the 2 medical providers designated by the City and County of Broomfield as primary care providers for the treatment of my on-the-job injury or illness for which this claim is being filed with Pinnacol Assurance who is the City and County of Broomfield's authorized workers' compensation insurance carrier.

Signature of Injured Worker: _____ Date Signed:

FOR ANY QUESTIONS NOT ADDRESSED BY THIS FORM, PLEASE CONTACT :

KRISTA RHODE – BENEFITS TECHNICIAN – 303-464-5816 (PRIMARY CONTACT)

VICKIE MAURI - HUMAN RESOURCES PROGRAM SPECIALIST - 303-438-6323 (SECONDARY CONTACT)

HUMAN RESOURCES MAIN PHONE NUMBER - 303-438-6320

PLEASE NOTE:

For each on-the-job injury or illness, the injured worker (or the worker's supervisor if the worker is incapacitated) needs to complete a First Report Of Injury form and submit it to Human Resources within 24 hours. The injured worker should also be aware that he/she has the choice between the two designated medical providers listed on the first page of the First Report of Injury form for his/her primary care treatment.

As soon as possible after the injury, the injured worker or supervisor must also complete an Accident/Injury Report. The supervisor should complete the Supervisor's Investigation Report. These reports should be submitted to Krista Rhode, Benefits Coordinator (303)464-5816, or Vickie Mauri, Benefits Administrator (303) 438-6323 within 7 business days of the date of injury.

For questions regarding medical benefits and lost wages, the injured worker should contact Pinnacol Assurance, the City and County of Broomfield's Workers' Compensation Insurance Carrier. Contact information is as follows:

Pinnacol Assurance
7502 E Lowry Blvd
Denver, CO 80230-7006
Customer Service Number: 303-361-4300 or 1-800-873-7242

Rev. 04/17/2014