Colorado

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	Date of hire	Occupation	Employment status	For Division use only
	☐ Married ☐ Separated ☐ Single ☐ Unknown			☐ Full time ☐ Part time ☐ Other ☐ Unknown	

Employer's name	Employer's Federal ID #	Employer's phone #	SOI
Nebraskaland Tire Inc dba Coloradoland Tire	470561185		

Employer's mailing address	City	State	Zip code	POB

Average weekly wage at time of injury $_____ (see instructions on reverse side)	Check box if employee receives	Check if these benefits are included in AWW	NOI
	☐ Tips ☐ Meals ☐ Room ☐ Health insurance	☐ Tips ☐ Meals ☐ Room ☐ Health insurance	Coder

Is the employer self-insured?	Were full wages paid for the DOI?	Are wages continued per C.R.S. 8-42-124? [1]
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Injury/Illness date (See instructions on reverse side)	Time employee began work	Injury time	Last day worked	Date employer notified	Date disability began	Date returned to work
	____ ____ ☐ 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)	Was the employee hospitalized overnight as an in-patient?
		☐ None ☐ Emergency room ☐ Minor on-site ☐ Hospital >24 hrs ☐ Clinic/hospital	☐ 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 ☐ Federated Mutual Insurance Company ☒ Federated Service Insurance Company	Address PO Box 419444, Kansas City, MO 64141-6444
Name of third party administrator (if applicable)	Address
Adjuster name	Adjuster phone # (800) 445-0109 Fax 866 636 8660

Policy # 339-495-4	Carrier claim #	Date insurer received first report	☐ Block # Mutual - 303 Service - 731	Adj. Code