WORKER'S COMPENSATION
FIRST REPORT OF INJURY

Broadspire Account Number 1244

AURARIA HIGHER EDUCATION CENTER™

TO BE COMPLETED BY EMPLOYEE

The Auraria Higher Education Center requires that any employee who has had a work-related incident, which results in illness/injury, must **report the incident immediately** to his/her supervisor and complete this form. Loss of benefits and penalties may be imposed if you fail to complete this form and return it to your supervisor.

A. EMPLOYEE INFORMATION:

First Name _____ Middle Name _____ Last Name _____

Street Address _____ City _____ State _____ Zip Code _____

Email Address _____ Phone Number _____

Date of Birth: _____ Age: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er)

Sex: ☐ Male ☐ Female Primary Language: _____ Social Security Number: _____

Job Title: _____ Date of Hire: _____ Employment Status: ☐ Full Time ☐ Part Time

Department: _____ ☐ Student ☐ Temp ☐ Other

B. EMPLOYER INFORMATION: **Auraria Higher Education Center**
Campus Box C, P.O. Box 173361
Denver, CO 80217-3361
Fax: 303-556-2448

C. WAGE/SCHEDULE INFORMATION:

Average Weekly Wage: _____ Hourly Wage: _____

Usual Work Schedule, Days Per Week *(check appropriate days)*: ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S

Hours Per Day: _____ From: _____ ☐ a.m. ☐ p.m. To: _____ ☐ a.m. ☐ p.m.

Scheduled Work Week When Injured *(check appropriate days)*: ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S

Hours Per Day: _____ From: _____ ☐ a.m. ☐ p.m. To: _____ ☐ a.m. ☐ p.m.

D. ACCIDENT INFORMATION:

Date of Injury: _____ Time of Injury: _____ ☐ a.m. ☐ p.m. Date Supervisor Notified: _____ Lost Time*: ☐ Yes ☐ No

A lost claim is when a worker misses more than 3 days (24 hours) from work for a work-related injury.

Last Day Worked: _____ Date Returned to Work: _____ Fatal Injury: ☐ Yes ☐ No

If Fatal, Date of Death: _____ Next of Kin: _____
(Full Name) *(Relationship)*

Street Address _____ City _____ State _____ Zip Code _____

PLEASE FAX OR EMAIL THIS REPORT IMMEDIATELY TO HUMAN RESOURCES (303-556-2448 or crystal.duran@ahec.edu)

...EMPLOYEE CONTINUED

Part of the Body Affected: _____

The Nature of the Injury: _____

What was the employee doing just before the accident occurred?

How the injury occurred?

What object or substance directly harmed the employee?

Did injury occur on premises: ☐ Yes ☐ No Injury Site *(address)*: _____

Initial Treatment: ☐ None ☐ Minoron Site ☐ Clinic ☐ Hospital ☐ Emergency Room

Was the employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

Name, address and phone number of treating doctor or other health care provider:

Clinic Name Doctor Name

Street Address City State Zip Code Phone Number

I hereby authorized any physician, hospital, individual or other entity to permit bearer or representative of AHEC Human Resources to view, copy, be furnished a copy, or be given details of all recorded information, in connection to all medical issues raised by the claim for workers' compensation benefits. A photocopy of this authorization shall be accepted with the same authority as an original. All information will be kept confidential.

AHEC POLICY IS TO HAVE A POST ACCIDENT DRUG TEST COMPLETED DURING THE INITIAL EVALUATION

I hereby declare under penalty of perjury that all statements contained herein, are to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Print Name Signature Date

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TO BE COMPLETED BY SUPERVISOR

E. ACCIDENT INVESTIGATION REPORT:

Injured Employee: _____ Employee Job Title: _____

Date of Accident: _____ Time of Accident: _____ ☐ a.m. ☐ p.m.

Accident Location: _____ Time Shift Started: _____ ☐ a.m. ☐ p.m.

Date Reported: _____ Time Reported: _____ ☐ a.m. ☐ p.m.

Was the accident caused by: ☐ Intoxication ☐ Failure to Use Safety Device(s)

Failure to Obey Safety Rule(s) ☐ Yes ☐ No Questionable Claim? ☐ Yes ☐ No

Description of Accident:

Witness: _____

Equipment Malfunction? ☐ Yes ☐ No

Basic Cause of the Injury:

Describe Any Unsafe Cause:

Describe Any Unsafe Conditions:

ACTIONS TO BE TAKEN TO PREVENT RECURRENCES:

Date Action Completed: _____

Supervisor Title Date

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DECLINING MEDICAL TREATMENT

I,_____ have chosen not to seek medical treatment for my injuries sustained on_____, to_____ and feel I am at maximum medical improvement.

(part of body)

If I chose to seek medical treatment at a later date I must get approval from my employer and Insurance carrier before seeking treatment.

_____

Signature Date

_____

Supervisor Signature Date

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