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 April 1, 2015: Injured Worker has the choice of the following four designated medical providers for primary care (select one):

Date of First Visit	Medical Facility Used
_____	SCL Physicians (Broomfield) – 12169 Sheridan Blvd; Broomfield, CO 80020 Phone: (303)603-9400
_____	SCL Physicians (Larkridge) – 16570 Washington Street; Thornton, CO 80023 Phone: (303)689-6600
_____	Arbor Occupational Medicine – 290 Nickel St, Suite 200; Broomfield, CO 80020 Phone: (303)460-9339
_____	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?): _____

(PLEASE COMPLETE ADDITIONAL INFORMATION ON PAGE 2)

Part(s) of Body Injured:

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_____, certify that I have received a copy of the letter regarding my choice for treatment from 1 of the 2 medical
(Injured Worker)
providers designated by the City and County of Broomfield as primary care provides 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 carrier.

Signature of Injured Worker: _____ Date:_____

By signing this document either written or electronic you certify that you are the injured person reference above and acknowledge that you have receive the choice of designated providers and that the information provided in this document is true.

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

KRISTA RHODE – RETIREMENT/LEAVE ADMINISTRATOR – 303-464-5816 (PRIMARY CONTACT)

VICKIE MAURI – BENEFITS ADMINISTRATOR- 303-438-6323 (SECONDARY CONTACT)

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