

READ INSTRUCTIONS
ON NEXT PAGE
BEFORE COMPLETION

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY

Employee's Name (First, Middle, Last)				SS#	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Employee's Home Phone No. ()	
Employee's Street Address				City	State	Zip Code	Occupation
Age	Birthdate Mo Day Year		Marital Status	How long has employee worked for this employer?		Job assigned when injured/exposed?	Length of experience at this assignment?
Years of Education Completed (circle one) 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20				Ethnic: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Do not wish to answer			

Employer's Name		Employer Federal I.D. No.	Employer's Phone No. ()	
Employer's Mailing Address		City	State	Zip Code
Location If Different From Mailing Address (Street Address)				
Nature of Business (specific product)			Number of Employees	

Are you receiving pay for: <input type="checkbox"/> Overtime Average Weekly \$ _____ <input type="checkbox"/> Commissions Average Weekly \$ _____ <input type="checkbox"/> Piecework Average Weekly \$ _____	Average Weekly Wage at Time of Injury \$ _____ (See Instructions on Next Page)	Hourly Wage at Time of Injury \$ _____	Hours Per Week
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Employee's Scheduled Work Week When Injured	Hours Per Day	Check Box If Employee Receives: <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Rooms <input type="checkbox"/> Health Ins. *	Will Benefit Continue During Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Average Weekly Value of Benefit \$ _____ \$ _____ \$ _____
Employee's Usual Work Schedule	Days Per Week			

*If health insurance benefit will not continue during disability, set forth employee's cost of continuing employer's health insurance or employee's cost of conversion \$ _____ per week. (See *)

Injury Date Mo Day Yr	Injury Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Last Day Worked Mo Day Yr	Date Employer Notified Mo Day Yr	<input type="checkbox"/> Date returned to work _____ <input type="checkbox"/> Estimated date of return _____
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Did injury cause death <input type="checkbox"/> Yes <input type="checkbox"/> No Date of death Mo Day Yr	Did injury occur because of <input type="checkbox"/> Intoxication <input type="checkbox"/> Failure to use safety devices <input type="checkbox"/> Failure to Obey Rules <input type="checkbox"/> Not Applicable
Name, Relationship, and Address of Closest Dependent of Deceased if Injury Caused Death	

Injury Description (State exactly the part of the body affected and the nature of injury or illness)

Names of Witnesses		Name of Employer Representative Notified		
Place of Accident/Exposure (see instructions on next page)	Address	City	State	Zip County
Name and Address of Treating Doctor		Name and Address of Hospital		

What happened to cause this injury or illness? Describe employee's activities when injury or illness occurred with details of how event or exposure occurred (include name(s) of other individuals involved, tools, machinery, objects, vapors, chemicals, radiations, unnatural motions of employee, etc). Also, specify the items which directly injured the employee and caused the accident or disease.

Authorized Company Representative (Signature)	Phone No. (include area code) ()	Position	Date Signed
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THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE INSURANCE CARRIER BEFORE THIS FORM IS FILED WITH THE COLORADO DIVISION OF WORKERS' COMPENSATION

Name of Insurance Company _____	Address _____				
WC1-Rev. 5-97	Policy No.	Carrier's No.	Adjustor Code	Date carrier received first report	Block No.

DO NOT WRITE IN SHADED AREAS

Accident Date
Area
SIC
Accident Time
Sex
Service
Occ
Source
Part of Body
Nature
Type
County
AWW
Coder
3rd Party
Scarring

INSTRUCTIONS

This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries & Illnesses"

General

You are hereby notified that if a child support obligation is owed, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S. YOU ARE FURTHER NOTIFIED that you must provide written notice of any award for social security, pension, disability or other source of income that might reduce your compensation benefits. This notice must be sent to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in suspension of your benefits pursuant to section 8-42-113.5, C.R.S.

- All injuries no matter how trivial must be reported to your insurance company.
- All injuries or occupational diseases which result in lost time from work in excess of three shifts or calendar days, or in permanent physical impairment, must be reported to your insurance carrier on this form within ten days after notice or knowledge of the injury or disease. Fatalities must be reported to your insurance carrier immediately.
- Forms should be typed or printed legibly.
- All questions must be answered completely to meet requirements of the Colorado Workers' Compensation Act and to conform to the OSHA requirements for Form No. 101.
- The employer may designate the treating physician. Contact your insurance carrier for details.

Average Weekly Wage

Calculate the average weekly wage as follows:

- Determine the weekly wage rate.
- Add the average weekly amount of any overtime wages, tips or commissions.
- Add the average weekly value of any board, rent, housing, or lodging provided by the employer if the employer will not be paying such benefit during the period of disability.
- Add the cost of health insurance when applicable (see instructions below).
- Compute the total and set forth under Average Weekly Wage at Time of Injury.

Health Insurance

Indicate whether the employee is covered by group health insurance. If so, indicate whether the employer plans to continue this benefit during the period of disability. If the employer does not continue the employee's health insurance coverage during the period of disability, the employer must set forth the employee's cost of conversion to a similar or lesser insurance plan, and include this cost in the average weekly wage computation.

Piecework

If the employee was paid by the piece, base the wage rate upon the average amount earned over a reasonable period of time preceding the injury.

Commissions

If the employee received a commission, include the average weekly commission in the average weekly rate over a reasonable period of time.

Truck Driver

If the employee is a truck driver who is paid by the mile, base the wage rate upon the average amount earned over a reasonable period of time preceding the injury.

Injury Information

DATE OF INJURY - In the case of an occupational disease, set forth the date of the first and last injurious exposure.

PLACE OF ACCIDENT/EXPOSURE - If accident/exposure occurred on employer's premises, give address of plant or establishment in which it occurred. If it occurred outside employer's premises at an identifiable address, give that address. If it occurred on a public highway or at any other place which cannot be identified by number and street, please provide place references locating the place of accident or exposure as accurately as possible. Include the county in the address.

C.R.S. Section 10-1-127(7) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."