

PINNACOL ASSURANCE

FIRST REPORT OF INJURY

To report a claim:
Call 303.361.4000 or 800.873.7242
Or Fax to 303.361.5000 or 888.329.2251
Or, go to www.pinnacol.com
PLEASE PRINT CLEARLY

Early reporting can save you money. Report all injuries immediately!

The information below allows Pinnacol Assurance's customer service representatives to quickly and accurately process your claim. Use the completed form as a guide when reporting by phone or online to save you time. Don't wait to report if you don't have all the answers.

POLICY INFORMATION

Policy Number: 4156349 Company Name: Manitou Springs School District 14
Address or Location (if different than mailing address): 405 El Monte Pl. Manitou Springs, CO 80829
Prepared by: Kolt Woofter Title: Payroll Specialist
E-mail: Please Print kwoofter@mssd14.org Fax: (719) 685 4536
Phone: (719) 685 2026 Date Completed: / /

INJURED WORKER INFORMATION

Injured Worker's Social Security Number: - - Date of Injury: / /
First Name: M.I. Last Name:
Home/Mailing Address: City State Zip Code Phone: () -
Date of Birth: / / Male Female Martial Status:
Language: English Spanish Other: E-mail:
Occupation: Date Hired: / /
Employee Status: Full-time Part-time Seasonal Volunteer Independent Contractor
Days Worked per Week: Hours Worked per Day:
Pay Rate: Hourly Weekly Monthly Annually Other:

ACCIDENT / INJURY INFORMATION

Fatal Injury: Yes No If Fatal Injury: Date of Death / /
Time of Injury: am pm Time Work Began: Last Day Worked: / /
Full Pay on Date of Injury: Yes No
Accident Occurred on Employers Premises: Yes No If Applicable: Location Code: Dept Code:
Accident Location: City State Zip Code
Name of Employer Representative Notified: Date Notified: / /
Witnesses:
Name(s) and Phone Number(s)

How Did the Injury Occur:
Specific Activity the Employee Was Engaged In: Attach Additional Information if Necessary What Equipment Was Being Used:
Body Part(s) Injured: Right Left Not Applicable
Type of Injury Sustained:
 Safety Equipment Provided Safety Equipment Used Possible Drug/Alcohol Involved Employer Questioning Liability

RETURN TO WORK INFORMATION

Has the Injured Worker Returned to Work? Yes No
Date Returned to Work: / / Estimated Return to Work Date: / /
Is this a lost time Claim? Yes No (Claim is lost time if there is a loss of more than three scheduled work days due to the injury).

MEDICAL PROVIDER INFORMATION: Where Was Your Employee Treated?

No Medical Treatment Treated by Employer 911 Called Walk-In Clinic
 Emergency Room Hospitalized > 24 hrs/Overnight Possible Surgery

Medical Provider Name Street Address City State Zip Code Phone

PINNACOL ASSURANCE FIRST REPORT OF INJURY FORM INSTRUCTIONS

1. Report all work-related injuries within 24 hours! Quick reporting can significantly reduce the total cost of the claim. Our **goal** is to get your employee back to work as quickly as possible and reporting within 24 hours streamlines that process. Report the injury to Pinnacol Assurance even if you question whether the injury is truly job related. Provide information as to why you question the validity of the claim.
2. This form is a guide for reporting injuries by phone, or fax using the numbers on the front of this form. Online reporting is fastest. To report online, go to www.pinnacol.com, select "Quicklinks," then "Report an Injury." The employer or authorized representative should report the injury to Pinnacol Assurance; please do not have the injured worker complete this form.
3. Within 7 days after notification of an injury, the employer is required to provide the injured worker with a list of four medical providers who have been designated by the employer to provide medical treatment for the injured employee. The injured worker must choose one of the designated providers from this list. Designating providers from Pinnacol's SelectNet list helps ensure your employee is seen by an occupational medical provider knowledgeable about the workers' compensation system and return to work issues. If you do not have four designated providers, call Pinnacol for assistance.
4. When reporting a claim by phone or the Internet, a copy of the completed form will be mailed to you for your records. Please review the copy to ensure all information is correct. If changes are needed, please contact Pinnacol's claim representative assigned to the claim.
5. If the injured worker owes court ordered child support, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee. (C.R.S. 8-42-124 & 26-16-122(4))

Please answer as many questions as possible for Pinnacol to begin processing the claim. Don't wait to report if you don't have all the answers, however all questions on this form will need to be completed in order to meet the requirements of the Colorado Workers' Compensation Act. **Especially critical is the information regarding Date of Injury, if the injured worker will miss more than three scheduled days from work, and when you expect the injured worker to return to work.**

Definitions:

Date of Injury: The date the accident occurred, or in the case of an occupational disease, the date of the first and last exposure.

Lost-Time Claim: The loss of more than three scheduled workdays due to the injury.

Wages and Time Worked: Provide either the weekly pay rate and hours OR the hourly pay rate and hours worked. Wages may also include: overtime wages, tips, commissions, room & board, housing, lodging and cost of health insurance. If you are unsure how to answer, call the customer service phone number on the front of this form. **Accident Location:** Provide the address if the accident occurred on the employer's premises or if it occurred outside the employer's premises at an identifiable location. If it occurred at a place that cannot be identified by a number or street, such as a public highway, provide references locating the place accurately as possible.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose 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 injured worker for the purpose of defrauding or attempting to defraud the policyholder or injured worker 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.

OSHA FORM 301 QUESTIONS "If you had 10 or fewer employees during all of the last calendar year or your business is classified in a low-hazard industry specified by OSHA, you do not have to keep injury and illness records unless the Bureau of Labor Statistics or OSHA informs you in writing that you must do so."

For this Pinnacol Assurance First Report of Injury to be considered equivalent to OSHA Form 301 (Injury and Illness Incident Report) the following questions must be completed along with the information on the front of this form. If you have questions regarding the OSHA recordkeeping standard contact your Pinnacol Assurance Safety Consultant.

Case Number from OSHA 300 Log _____ Was the Employee Hospitalized Overnight as an In-Patient? Yes No

What was the Employee doing just Before the Incident Occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials," "spraying chlorine from hand sprayer," "daily computer key-entry."

What was the Injury or Illness? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." Examples: "strained back," "chemical burns to hand," "carpal tunnel syndrome."

What Object or Substance Directly Harmed the Employee? Examples: "concrete floor," "chlorine," "radial arm saw." *If this question does not apply to the incident, leave blank.*

What was the Name of the Physician/Health Care Professional Who Provided Medical Treatment to the Employee?

10/1/21

**MANITOU SPRINGS DISTRICT 14
WORKERS' COMPENSATION DESIGNATED MEDICAL PROVIDERS
FOR WORK-RELATED INJURIES
(Effective April 1, 2016)**

All employees must immediately report any work related injury to their supervisor (for assistance, if necessary, and to initiate a First Report of Injury form), and must obtain treatment for work-related injuries from:

**Concentra Medical Centers
Colorado Springs – North
5320 Mark Dabbling Blvd.
Colorado Springs, CO 80918
719-592-1584
8:00 a.m. – 5:00 p.m., M-F**

**Integrity Urgent Care PC – West - 1058899
1035 Garden of the Gods Rd., Suite 120
Colorado Springs, CO 80907
719-329-1000
8:00 a.m. – 5:00 p.m., M-F
8:00 a.m. – 6:00 p.m., Sat-Sun**

OR

OR

**HealthQuest Medical, Inc.
1495 Garden of the Gods Rd., Suite 102
Colorado Springs, CO 80907
719-260-9797
8:00 a.m. – 5:00 p.m., M-F**

**Emergicare
402 W. Bijou
Colorado Springs, CO 80903
719-302-8942
8:00 a.m. – 5:00p.m., M-F**

If an unauthorized medical provider treats an employee, the employee will be responsible for payment of said treatment.

In the event of a non-emergency after hours work-related injury, contact one of the providers at the non-emergency numbers listed above.

At any time, in the event of a life-or-limb threatening emergency or other serious work-related injury, your first objective is to seek medical treatment, which may be at the nearest emergency medical facility. You must inform the caregiver that you are a Manitou Springs School District 14 employee, that you were injured on the job, and that the school district's workers' compensation carrier is Pinnacol Assurance so that you will not be held responsible for payment of treatment. One of the medical providers listed above must provide all follow-up care. As soon as possible, either before or after emergency treatment, you must notify your supervisor of the injury.

An injured employee has the right to make a one-time change between an employer's two designated medical providers by providing written notice within 90 days of the injury, but before reaching maximum medical improvement.

The injured employee must provide notice of the change in writing by submitting an approved Colorado Division of Workers' Compensation form to:

- MSSD14 workers' compensation carrier (Pinnacol Assurance)
- The initial authorized treating physician (Concentra, HealthQuest or Emergicare)
- The newly authorized treating physician (Concentra, HealthQuest or Emergicare)
 - The MSSD14 business services office

The address for MSSD14's workers' compensation carrier is:
Pinnacol Assurance, 7501 E. Lowry Blvd., Denver, CO 80230-7006
Phone: 800-873-7242 / 303-381-4000

A COPY OF THIS NOTICE WAS PROVIDED TO ME ON: _____ (Date)

NAME _____ SIGNATURE _____