



# Grand Junction First Report of Injury

Hilltop Community Resources  
1331 Hermosa Avenue  
Grand Junction, Colorado  
81501

\*PeopleOps Use\*

Date Received: \_\_\_/\_\_\_/\_\_\_

Date Submitted: \_\_\_/\_\_\_/\_\_\_

Claim #: \_\_\_\_\_

Report all injuries immediately. Don't wait to report if you don't have all the answers.

## EMPLOYEE INFORMATION

Injured Worker's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Home/Mailing Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status: \_\_\_\_\_ Language:  English  Spanish  Other: \_\_\_\_\_

E-mail: \_\_\_\_\_

Program: \_\_\_\_\_ Position: \_\_\_\_\_

Hire Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employee Status: \_\_\_\_\_

Days Worked per Week: \_\_\_\_\_ Hours Worked per Day: \_\_\_\_\_ Pay Rate: \_\_\_\_\_

Schedule: \_\_\_\_\_

Direct Supervisor: \_\_\_\_\_ Number: \_\_\_\_\_

## ACCIDENT/INJURY/ILLNESS INFORMATION

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time Arrived at Work: \_\_\_\_:\_\_\_\_ Time of Injury: \_\_\_\_:\_\_\_\_

Address: (location of injury): \_\_\_\_\_

Body Part(s) Injured: \_\_\_\_\_

Employee's Explanation of Injury:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name/Phone Number of Witness(es): \_\_\_\_\_

Was there a safety violation?  YES  NO

Machine Malfunction?  YES  NO

Motor Vehicle Accident?  YES  NO

Did the employee leave work?  YES  NO



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### TYPE/CAUSE/LOCATION OF INJURY

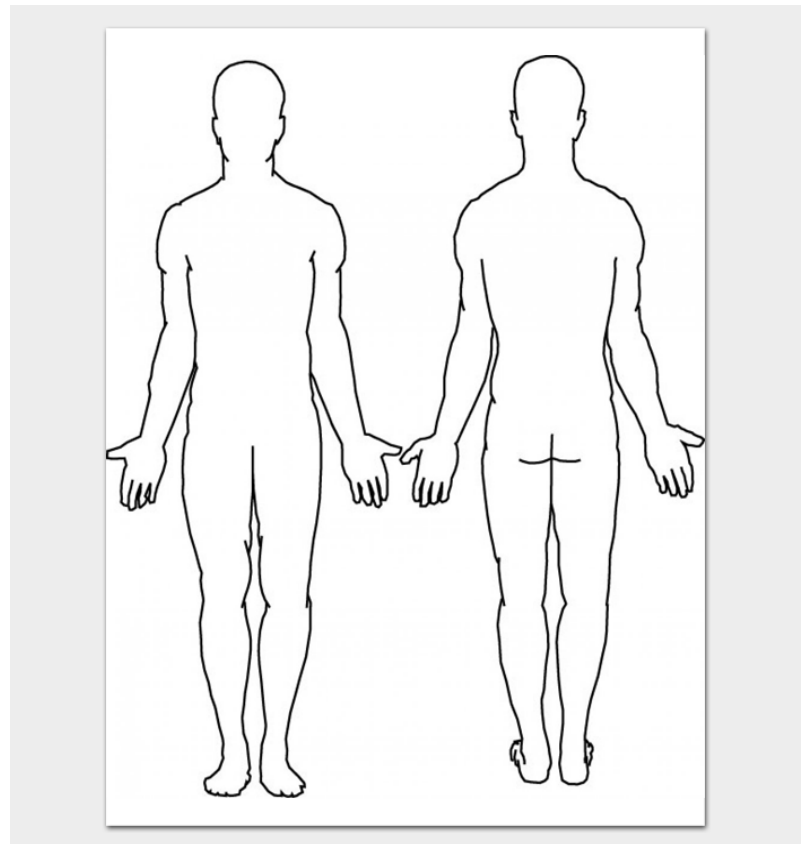
Mark Areas of Injury Below:

**Type of Injury (check which apply):**

- Scrape/Bruise
- Sprain/strain
- Puncture wound
- Cut/laceration
- Concussion
- Bite
- Chemical burn/rash/breathing difficulties
- Other:
- No apparent injury

**Cause of Injury (check which apply):**

- Slip/fall
- Struck by equipment
- Lifting or moving
- Needle puncture
- Object in eye
- Repetitive/overuse
- Other:





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### ACCEPTING/DECLINING TREATMENT

**Sign this section if you are accepting medical treatment:**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Representative Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**Sign this section if you are refusing medical treatment at this time:**

I have been offered medical treatment but decline at this time. This does not prevent me from receiving treatment in the future for this injury.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Representative Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### MEDICAL PROVIDER INFORMATION

Where Was Your Employee Treated?

- Employee Declined Treatment       911 Called  
 Walk-In Clinic       Emergency Room       Hospitalized > 24 hrs./Overnight

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Medical Provider Name	Street Address	City	State	Zip Code	Phone
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## Hilltop Community Resources, Inc. Investigative Report

The supervisor must fill out this Injury and Illness Report when a work-related injury or illness has occurred within 72 hours of occurrence. This form is an equivalent form for the OSHA form 301.

According to the Public Law 91-596 and 29 CFR 1904, OSHA’s record keeping rule, this form must be kept on file for 5 years following the year to which it pertains. This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

### Information about the employee:

1. Full name: \_\_\_\_\_  
(Last, first, middle initial)

### Information about the physician or medical professional:

2. Name of physician or medical professional if medical attention was necessary  
\_\_\_\_\_

3. If treatment was given away from the worksite, where was it given?

\_\_\_\_\_  
Facility Name                      Address                      City                      State                      Zip Code

4. Was the employee treated in an emergency room?       YES       NO  
5. Was the employee hospitalized overnight as an in-patient?       YES       NO

### Information about the case:

6. Date of Injury or Illness: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

7. 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.”

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. 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.”

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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9. 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.

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10. Interview Witness(es). Document their observations and collect their written statements. Did anything unexpected or unusual happen?

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11. What actions have been taken to prevent reoccurrence?

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12. Supervisor Comments:

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13. If employee died, when did death occur? Date of death: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Completed by: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Representative Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



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### Injured Employee Information

1. We are committed to your recovery being as swift as possible. We want to work with you to reach that goal. Hilltop will provide modified duty with ANY restrictions the doctor provides.
2. If medical treatment is needed, choose one of the designated medical providers: Under the Worker's Compensation Law, your employer may select your treating physician. Seeing another doctor without approval is unauthorized and will not be paid by the insurance company. If you receive emergency medical care, you must still follow-up with the designated doctor.
3. There are forms that must be completed at each visit. Before you leave the doctor's office, be sure you have a form that specifically states what restrictions, if any, you have on your activity. Bring the completed form to the corporate office after each visit.
4. Notify the People Ops Specialist and your supervisor of the time and date of each clinic appointment. If you need to cancel an appointment for any reason, notify the People Ops Specialist as soon as possible and reschedule the appointment within 24 hours. You may not miss work for a worker's compensation injury without an examination and authorization from the medical provider.
5. Schedule follow-up medical and physical therapy appointments outside of work hours whenever possible. Contact the People Ops Specialist if you think this will be a problem.
6. A representative from Pinnacol may be in contact with you by telephone or in person.
7. Please submit bills from physicians, pharmacies, etc., to the People Ops Specialist.
8. Please speak with your supervisor or People Ops Specialist if you have any questions or concerns.
9. Failure to follow these worker's compensation injury instructions may result in disciplinary action, which may include termination.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Representative Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



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**Hilltop Community Resources, Inc.**

### Workers' Compensation Injuries Designated Provider List

**\*KEEP ONE COPY FOR EE FILE AND GIVE ONE COPY TO EE FOR THEIR RECORDS\***

For on-the-job injuries, you may choose one of the following authorized medical providers:

<b>WorkPartners</b> 2646 Patterson Road Suite A Grand Junction, Colorado 81506 (970)241-5585	<b>St. Mary's Occupational Medicine</b> 2686 Patterson Road Grand Junction, Colorado 81506 (970)298-2001	<b>Western Valley Family Practice</b> 281 N. Plum Street Fruita, Colorado 81521 (970)858-9894
<b>DCMH Family Medicine</b> 555 Meeker Street Delta, Colorado 81416 (970)874-5777		
<b>Peak Family Medicine</b> 1550 E. Niagra Road Montrose, Colorado 81401 (970)497-4921	<b>Cedar Point Health</b> 836 S. Townsend Avenue Suite A Montrose, Colorado 81401 (970)615-9120	

**In the case of an emergency situation, you should go to:**

Community Hospital Emergency Department  
2351 G Road  
Grand Junction, CO 81505

For further treatment, report to one of the above designated providers for follow-up care.

The following are designated as the Employer and Administrator Representatives:

**Designated Employer Representative:**

Emily Schultheis  
Phone: (970)244-0531  
Hilltop Community Resources  
1331 Hermosa Avenue  
Grand Junction, CO 81506

**Insurer/TPA Representative:**

Insurer: Pinnacol Assurance  
Adjuster Number: 1-800-873-7242  
Mailing Address: 7501 E. Lowry Blvd  
Denver, CO 80230

This list was provided to \_\_\_\_\_

by \_\_\_\_\_ on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

- Hand Delivery
- U.S. Mail

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Representative Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



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