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.
Please send completed form to workerscomp@htop.org

EMPLOYEE INFORMATION

Injured Worker's Social Security Number ___________________-________________-_______________

First Name:_____________________________M.I._____Last Name: ___________________________

Home/Mailing Address: ____

City State Zip Code

Phone: (______)________-__________ 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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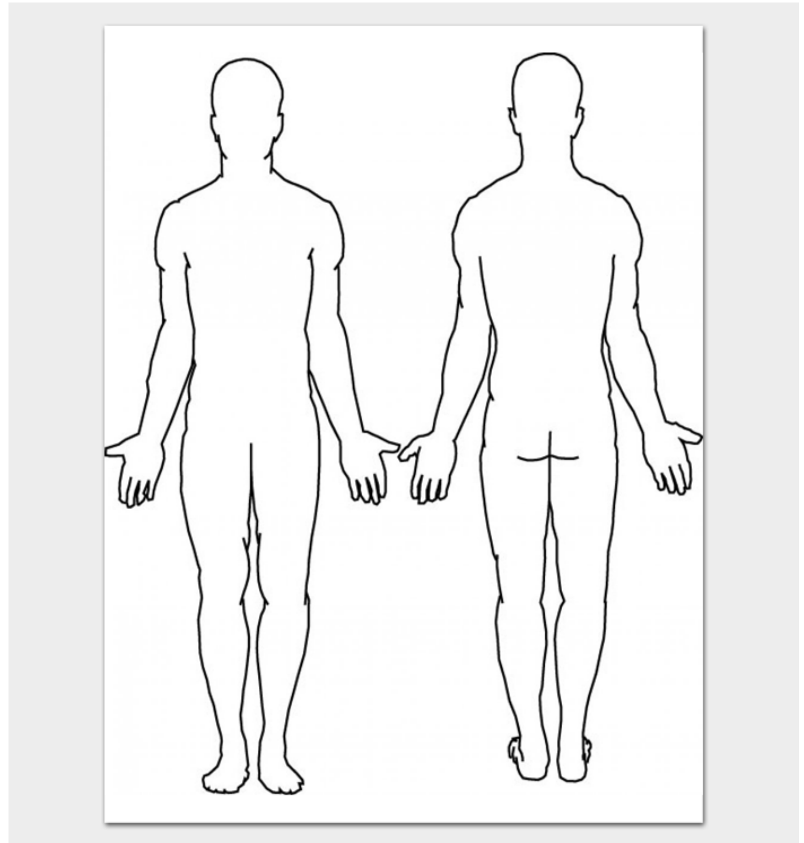
TYPE/CAUSE/LOCATION OF INJURY

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:_____/____/_____

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

____

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."

   ____
   ____
   ____

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.

____
____

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

____
____
____

11. What actions have been taken to prevent reoccurrence?

____
____
____

12. Supervisor Comments:

____
____
____

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:

WorkPartners **2646 Patterson Road Suite A** **Grand Junction, Colorado 81506** **(970)241-5585**	**Grand Valley Occupational Health** **2004 N. 12th Street** **Grand Junction, CO 81506** **(970)644-3700**	**Western Valley Family Practice** **281 N. Plum Street** **Fruita, Colorado 81521** **(970)858-9894**
DCMH Family Medicine **555 Meeker Street** **Delta, Colorado 81416** **(970)874-5777**		
Peak Family Medicine **1550 E. Niagara Road** **Montrose, Colorado 81401** **(970)497-4921**	**Cedar Point Health** **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:
Linda Withem
Phone: (970) 244-0415
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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by________________________________ on__________ /__________/ __________

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☐ U.S. Mail

Employee Signature:_________________________ Date:____/____/_____

Employee Representative Signature:_________________________Date: