



First Report of Injury
 Hilltop Community Resources
 1331 Hermosa Ave
 Grand Junction, CO 81506

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: _____

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: _____ Phone: _____

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

TYPE/CAUSE/LOCATION OF INJURY

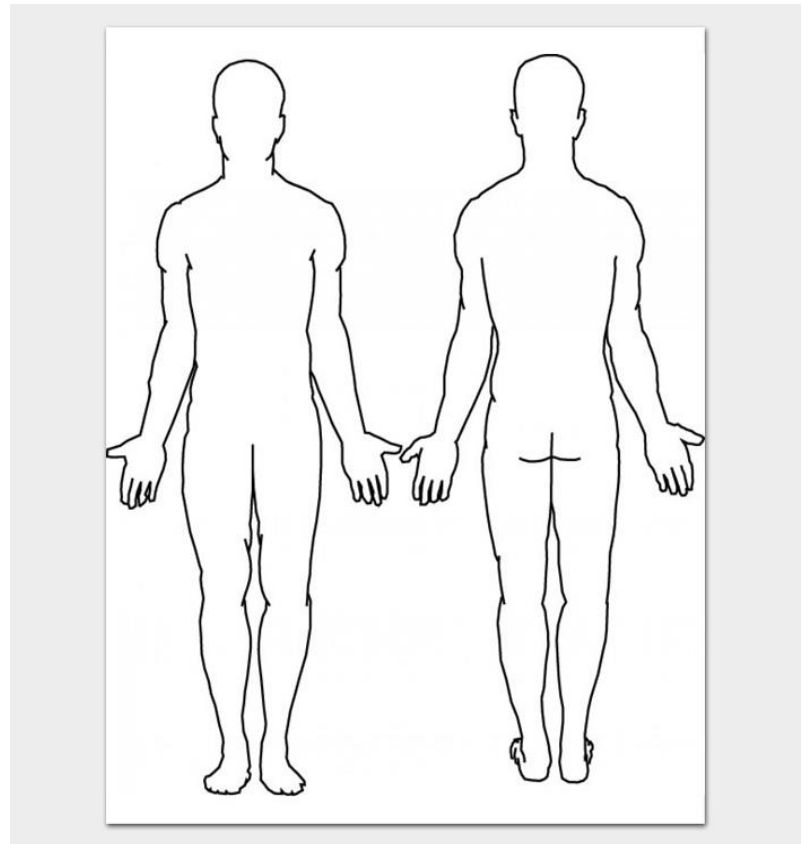
Mark Areas of Injury Below:

Type of Injury (check which apply):

- No apparent injury
- Scrape/bruise
- Sprain/strain
- Puncture wound
- Cut/laceration
- Concussion
- Bite
- Chemical burn/rash/breathing difficulties
- Exposure to blood or bodily fluids
- Other: _____

Cause of Injury (check which apply):

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



For Exposure to Blood or Bodily Fluids Only (check which apply):

Type of Exposure

- Contaminated Sharp
- Mucous Membrane Exposure
 - Eyes
 - Mouth
 - Nose
- Skin Exposure
 - Open Cut
 - Abrasion

How did exposure occur?

- Disposing of needle/sharp in sharps box
- Full sharps box
- Recapping needle
- Other: _____

If an employee has been exposed to blood or bodily fluids, they must sign page 9 and be sent to Community Hospital Laboratory or Work Partners to start the exposure process within 24 hours of being exposed.

The person whose blood/bodily fluids they were exposed to should also sign page 10 and be sent to be tested as well.



Hilltop Community Resources 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. 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.

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: _____

Signature: _____

Phone: (_____) _____ Date: _____/_____/_____

Employee 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 may 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. Send or bring the completed form to the People Ops Generalist after each visit.
4. Notify the People Ops Generalist 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 Generalist as soon as possible and reschedule the appointment within 24 hours.
5. You may not miss work for a worker's compensation injury without an examination and authorization from the medical provider.
6. A representative from Pinnacol will be in contact with you by telephone, email, and/or mail.
7. Please submit bills or receipts from physicians, pharmacies, etc., to the People Ops Generalist.
8. Please speak with your supervisor or People Ops Generalist if you have any questions or concerns.
9. Failure to follow these workers' compensation injury instructions may result in disciplinary action, which may include termination.

Employee Signature: _____ Date: ____/____/____



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Workers Compensation Designated Provider List

Keep one copy for the employee file and give one copy to employee for their records

For work-related injuries, you may choose one of the following designated medical providers:

WorkPartners 2646 Patterson Road Suite A Grand Junction, CO 81506 (970) 241-5585	Grand Valley Occupational Health 2020 N. 12 th Street Grand Junction, CO 81506 (970) 644-3700	Family Health West Primary Care (Redlands) 2237 Redlands Pkwy Grand Junction, CO 81507 (970) 858-9894
Family Health West Primary Care (Fruita) 401 Kokopelli Blvd Unit 1 Fruita, CO 81521 (970) 858-9894	For Montrose/Delta Employees: DCMH Family Medicine (Delta) 70 Stafford Lane Delta, CO 81416 (970) 874-5777	For Montrose/Delta Employees: Peak Family Medicine (Montrose) 1550 E. Niagara Road Montrose, CO 81401 (970) 497-4921

In case of an emergency, you should go to:

For Grand Junction Employees: Community Hospital Emergency Department 2351 G Road Grand Junction, CO 81501	For Montrose/Delta Employees: Montrose Memorial Hospital Emergency Department 800 S 3 rd St Montrose, CO 81401
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For further treatment after the initial emergency treatment, you will need to 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: PeopleOps Generalists - Hilltop Community Resources 1331 Hermosa Avenue Grand Junction, CO 81506 Phone: (970) 242-4400	Insurer/TPA Representative: Pinnacol Assurance 7501 E. Lowry Blvd Denver, CO 80230 Adjuster Number: 1-800-873-7242
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This list was provided to _____ by _____
Employee Name Supervisor Name
 on _____
Date

Employee Signature: _____ Date: ____/____/____

Supervisor/Leader Signature: _____ Date: ____/____/____



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Workers Compensation Designated Provider List

Keep one copy for the employee file and give one copy to employee 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, CO 81506 (970) 241-5585	Grand Valley Occupational Health 2020 N. 12 th Street Grand Junction, CO 81506 (970) 644-3700	Family Health West Primary Care (Redlands) 2237 Redlands Pkwy Grand Junction, CO 81507 (970) 858-9894
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This list was provided to _____ by _____
Employee Name Supervisor Name
 on _____
Date

Employee Signature: _____ Date: ____/____/____

Supervisor/Leader Signature: _____ Date: ____/____/____



Only have the employee fill out this form if they were exposed to blood or bodily fluids. If the employee did not have an exposure, you can shred this page.

**Exposure Protocol
Employee Consent Form**

I, _____, consent to have a blood test to detect antibodies to the Human Immunodeficiency Virus (HIV), Hepatitis B and Hepatitis C. This test is being conducted as part of the established protocol for protection of employees exposed to blood or bodily fluids.

The HIV antibody, Hepatitis B, and Hepatitis C tests can be performed by Community Hospital laboratory or WorkPartners. The results of the tests are confidential. The results will be discussed with you at the follow-up appointment with your choice of designated provider. The Public Health Department will be notified of positive results (as required by Colorado law), which will be held in strict confidence.

Medical evaluations and procedures including the Hepatitis B vaccine, post-exposure evaluation and follow up are available at no cost to the employee.

Employee Signature

Date



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Only fill out this page with the participant or resident if an employee was exposed to their blood or bodily fluids. If the employee did not have an exposure, you can shred this page.

**Exposure Protocol
Source/Client Information Consent Form**

An employee of Hilltop Community Resources has been exposed to blood and/or bodily fluids while performing duties related to your care. As a result, a sample of your blood is needed for HIV antibody and Hepatitis B and C testing. These are infectious diseases which can be transmitted by blood/bodily fluid exposure.

The HIV antibody, Hepatitis B, and Hepatitis C tests can be performed by Community Hospital laboratory or WorkPartners. The results of the tests are confidential. The results will be discussed with you at the follow-up appointment with your choice of designated provider. The Public Health Department will be notified of positive results (as required by Colorado law), which will be held in strict confidence.

Patient, Parent, or Legal Guardian Signature

Date