CHERRY CREEK SCHOOL DISTRICT #5 EMPLOYER'S FIRST REPORT OF INJURY

___ I am filing a claim and will be seeking medical treatment ___ I am filling a report only and do not want to seek medical treatment at this time	Name of Building Where Injury Occurred:	Date of Injury: Date of Hire:	Employee's Social Security Number: Employee's District ID#:
Employee's Last Name:	Employee's First Name:	Date of Birth:	Work Phone Number:
Employee's Street Address:	City/State:	Zip Code:	Personal Phone Number:
Employee's Personal Email Address:	Gender: ___M ____F	Marital Status: _____Married _____Single _____Seperated/divorced	Employment Status: __FT ___PT ___ Other
Occupation:	Supervisor's Name:	# of Hours Worked Per Day _____ # of Hours Worked Per Wk _____	Time Employee Began Work:
Time Injury Occurred:	Date Employer Notified of Injury:	Last Day Employee Worked:	Did the Injury Occur on the Premisis? ___ yes ___ no

Initial Treatment: _____ None _____ School Nurse _____ Work Comp Clinic _____ ER/Urgent Care

Name of Witnessess to the Injury/Illness:
Name:_____ Phone: _____
Name:_____ Phone:_____

Please nswer the following questions to further describe the injury:

1. Have you been injured on the job before? ___No ____Yes If so for what body part?_____
2. Did this accident aggravate a previous work or no-work injury? ____No _____Yes
3. What type of shoes was the employee wearing? _____
4. Did the employee fail to use safety devices/PPE or obey safety rulles? ____ No ____ Yes

Nurses Evaluation: A school nurse does not need to be a part of filling out this form unless medical attention is needed.

Describe in detail what happened. Please be as specific as possible.

What was the employee doing at the time of the injury?	What object or substance harmed the employee?	What Body Parts Were Affected?

Please Put a Check Mark in the Box Below for the Designated Provider You Choose To See If Seeking Treatment

____ Injury Care Associates-Parker 19284 Cottonwood Dr. Suite #104 Parker, Co 80138 (720) 409-0007 Monday-Friday 7am-5pm	____ Occupational Medical Partners – Aurora 1390 S. Potomac St. Suite #136-East side of Bldg. Aurora, Co 80012 (303)214-0000 Monday-Friday 7am-5pm	____ Concentra- Tech Center 11877 E. Arapahoe Rd. Suite #100 Centennial, Co 80112 (303)792-7368 Monday – Friday 8am-5 pm	____ Dr. Martin Kalevik - Parker 19284 Cottonwood Dr. Suite #104 Parker, Co 80138 (720) 409-0007 Monday-Friday 7am-5pm

In Case of Serious Injury Call 911 or go to the Nearest Medical Facility.
Follow UP Care Needs to be Provided at One of the Above Selected Designated Providers the The Following Day.

C.R.S. Section 10-1-128(6) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company or authorized third party administrator, for the purposes of defrauding or attempting to defraud the company. Penalties may include fines, denial of insurance, civil damages, and/or imprisonment.

_____ _____

Injured Employee Date Supervisor/ Person Notified Date