El Paso County

Risk Management
2880 International Cir., Suite N060
Colorado Springs, CO 80910
(719) 520-7486/7488 - *phone*
(719) 520-7406 - *fax*

Employee Written Notice of Injury

RISK MANAGEMENT MUST BE NOTIFIED WITHIN 4 DAYS OF INJURY

Section 1: To be Completed by Employee

Employee's Name: (Last, First, Middle Initial)			Department:	Job Title:
Home Address:			Supervisor Name:	
City:	State:	Zip:	Date of Hire: ___/___/____	Work Phone Number:
Home Phone Number:			Number of hours per day you work?	Days per week you work (circle): SU M T W TH F S
Alternate/Cell Phone Number:				
Social Security Number:			Do you currently have health insurance? Yes ☐ No ☐	
Date of Birth: ______/______/______	Gender (circle): Male Female	Marital Status (circle): Single Married	Do you currently have a second job? Yes ☐ No ☐ If yes, where? ____________________	

Injury Information

Date of Injury: __________/__________/__________	Time of Injury: __________________ AM ☐ PM ☐	
Were you performing your regular job assignment at the time of injury? Yes ☐ No ☐ If no, what was your job assignment? ____________________	What object or substance directly harmed you?	Who did you first report this to, and when?
Exact Location where Accident/Exposure Occurred:		
What part of your body was affected? (specify *upper* or *lower* for arm, legs and back injuries)		
How did the Injury/Accident Occur?		
Please list any Witnesses:		
Did another person contribute (cause) to your injury? Yes ☐ No ☐ If yes, please explain:		
Do you feel that you need medical attention? Yes ☐ No ☐ If no, please initial and date here__________________________		
Recommended corrective actions to prevent reoccurrence:		

I understand it is unlawful to make fraudulent claims. Any person who makes or causes to be made, any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying Workers' Compensation benefits or payments is guilty of a felony and may be prosecuted.

Employee Signature:	Date: _______/_______/_______

Section 2: To be Completed by Supervisor

What was the employee doing at the time of the injury?		Was the employee able to return to work? Yes ☐ No ☐	
Did injury occur because of: ☐ Failure to use safety device ☐ Failure to obey safety rule ☐ Intoxication or drug abuse ☐ Other:__________________			
Action Taken/Proposed to Prevent Future Incidents:			
Supervisor Name: *(please print)*	Supervisor Signature:	Phone Number:	Date: _______/_______/_______

Incomplete forms will not be processed, and will be returned to the employees' department for completion.