



EMPLOYEE STATEMENT FOR WORKER'S COMPENSATION CLAIM

A. Critical Data:

Policy Number: 1244 Mesa State College 1100 North Avenue Grand Junction, CO 81501

Social Security Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Name: \_\_\_\_\_
(first) (middle initial) (last)

B. Injured Worker Information:

Home phone: \_\_\_\_\_
(use 999-999-9999 format)

Home Address: \_\_\_\_\_
(street) (city/state) (zip code)

Date of Birth: \_\_\_\_\_ Date Hired: \_\_\_\_\_
(use mm/dd/yyyy format) (use mm/dd/yyyy format)

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Widowed [ ] Divorced [ ] Unknown

Language: [ ] English [ ] Spanish [ ] Other Sex: [ ] Male [ ] Female

Occupation: \_\_\_\_\_

Employee Status: [ ] Full-time [ ] Part-time [ ] Seasonal [ ] Volunteer [ ] Student [ ] Other

Wage Rate: \_\_\_\_\_ per \_\_\_\_\_

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

C. Policy Designation:

Department: HE - Department of Higher Ed. Division: HEMS - Mesa State College

D. Accident Information:

Was injury fatal? [ ] Yes [ ] No Date of Death: \_\_\_\_\_

Accident Occur on Premises: [ ] Severe Injury: [ ]

Accident Location: \_\_\_\_\_

State of Accident: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Notified Name: \_\_\_\_\_

Date Employer Notified: \_\_\_\_\_

How did injury occur? \_\_\_\_\_
(200 characters max)

Specific Activity Engaged In: \_\_\_\_\_

What Equipment Was Used: \_\_\_\_\_

Body Parts Injured: \_\_\_\_\_

Lost Time Claim? [ ] Yes [ ] No [ ] Unknown

(A lost-time claim is a claim in which the worker misses more than three days/shifts from work due to a work-related injury. If anticipated missed work totals more than three scheduled days/shifts, please mark yes.)

**E. Injury Information:**

Time of Injury: \_\_\_\_\_  a.m.  p.m. Time Work Began: \_\_\_\_\_  a.m.  p.m.

Last Work Date: \_\_\_\_\_ Full Pay on Date of Injury:  Yes  No

Returned to Work:  Yes  No Date Returned to Work: \_\_\_\_\_

Estimated Date of Return to Work: \_\_\_\_\_

Witness(es) Name(s): \_\_\_\_\_

Witness(es) Phone: \_\_\_\_\_  
*(use 999-999-9999 format)*

Safety Equipment Provided:  Yes  No  Unknown

Safety Equipment Used:  Yes  No  Unknown

**F. Medical Information:**

No Medical Treatment:  (Check if no medical treatment has been provided)

Treated by Employer:  Yes  No  Unknown

Was 911 Called:  Yes  No  Unknown

Walk-in Clinic:  Yes  No  Unknown

Emergency Room:  Yes  No  Unknown

Hospitalized > 24 Hours:  Yes  No  Unknown

Possible Surgery:  Yes  No  Unknown

Medical Provider Name: (circle one)

Western Medical Associates  
1060 Orchard Avenue  
Grand Junction, CO 81501  
970-241-7600

St. Mary's Occupational Health Center  
1100 Patterson Road  
Grand Junction, CO 81506  
97.0-244-2001

Community Hospital  
2021 North 12  
Grand Junction, CO 81501  
ER: 970-256-6400

St. Mary's Hospital  
2635 N. 7<sup>th</sup> Street  
Grand Junction, CO 81502  
970-244-2273

Other: \_\_\_\_\_  
\_\_\_\_\_

Comments or Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is Mesa State College your only employer?  Yes  No

If no, who is your secondary employer? \_\_\_\_\_

What are your position title and duties? \_\_\_\_\_

Last date worked for secondary employer: \_\_\_\_\_

By signing below, I certify that the information provided on this form is true and accurate to the best of my knowledge.

**G. Employee Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_