EMPLOYEE STATEMENT FOR WORKERS COMPENSATION CLAIM

A. Critical Data:

Policy Number: 4140856 Colorado Mesa University 1100 North Avenue Grand Junction, CO 81501

Social Security Number: ______________________________ Date of Injury: ____________________

Name: ____
(first) *(middle initial)* *(last)*

B. Injured Worker Information:

Home phone: ______________________________ Cell: ______________________________
(use 999-999-9999 format) *(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 - Colorado Mesa University

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)

Pavilion Family Medicine	Montrose Wellness Center	Emergency: Montrose Memorial Hospital
1804 E Pavilion Suite B	224 S Nevada Avenue	800 South 3rd Street
Montrose, CO 81401	Montrose, CO 81401	Montrose, CO 81401
970-249-6670	970-252-9644	970-874-4610

Other: ____
____

Comments or Additional Information: ____
____
____
____

Is Colorado Mesa University your only employer? ☐ Yes ☐ No
If no, who is your secondary employer? ____
What are your position title and duties for secondary employer? ___________________________
____
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:_______________