

Durango Fire & Rescue Authority

Injury Report Form

For Office Use Only **Report #:** _____ **Date Received:** _____

Involved Member: _____

This report is for preventing future injuries to your fellow firefighters.

Injury requiring treatment – Take the injured member immediately to Mercy Medical Center. Notify the ER that this is a Workers Comp claim for DFRA and no claim # is required. Notify Safety Officer immediately by radio or phone in reference to serious injuries.

For **EMS Exposures** have injured party fill out EMS Exposure Report form (in addition to this report) and submit to Human Resources. Preparation and submission of the front page, and Parts I & II of this form or EMS Report must be completed within 24 hours of incident and submitted to HR Director. Witness form must be completed within 48 hours. HR Director will report injuries that do or may require seeing a doctor to Workman’s Comp. within 24 hours (if accident occurs on weekend the report will be filed first thing Monday morning.).

Worker Compensation Carrier:

Department Insurance Policy # - 3W521199-354 – Colorado Special Districts Property & Liability Pool.
800 Grant St. – Suite 400, Denver, CO 80203

Where to go for treatment:

Emergency – Mercy Regional Emergency Room – 1010 Three Springs Blvd.

Non Emergency:

Occupational Medicine - 1 Mercado Street, Ste 275 (Medical Plaza of Mercy Regional Med. Ctr) Ph: 764-3850
La Plata Family Medicine – 3235 N. Main Ave Ph: 259-3110

Date Employer Notified: _____ Name of Employer Representative Notified: _____

Type of Incident: (Circle as many as apply)

Near Miss – Equip. Damage - Vehicular Accident - Injury/Illness - Property Damage – EMS Exp.

Short Description: _____

•Employee Status: Full-time Part-time/Reservist Volunteer

Was this during an Emergency Response? Yes No

•Were Safeguards or Safety Equipment Provided: Yes No •Used: Yes No

•Intoxication Involved? Yes No Did this accident/injury take place during an incident? Yes No

Witnesses:

Name	Phone	Address	Affiliation	Date Report Received

***if a witness is listed – a witness report form must be completed.**

Describe what you see as the cause of this incident and what should be done to avoid this type of incident in the future:

(circle if more on back) OVER

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INJURY REPORT PART 1 - EMPLOYEE

Report # _____

Colorado Special Districts Property & Liability Pool Employee's Written Notice of Injury to Employer

Please read instructions on reverse side before completing this form. Note to Employer: You are required to complete the Employer's First Report of Injury.

1.	Name of Employer:	Phone:	
2.	Name of Injured Employee:	Social Security #:	
3.	Home Address:	Phone:	
4.	Age:	5. Birth Date:	6. Sex:
7.	How long employed by employer?	8. Employee occupation:	
9.	Place of accident/exposure: (see instructions on reverse side) (No. & Street) (City) (State) (Zip)		
10.	What was employee doing when injured? (Be specific. If using tools or equipment, name them and tell how they were being used.)		
11.	How did the accident occur? (Describe fully the events which resulted in the injury/occupational illness. Tell what happened and how it happened. Give full details on all factors which led or contributed to the accident/exposure. Use separate sheet if additional space is needed)		
12.	Name the object or substance which directly affected the employee: (For example, the machine or thing he struck against or which struck him; the vapor or poisons inhaled or swallowed; the chemical or radiation which irritated the skin or in the case of strains hernia etc the thing lifted pulled etc.)		
13.	Describe the injury/illness in detail and indicate the part of the body affected:		
	For example, amputation of right index finger at second joint; fracture of ribs; lead poisoning; dermatitis of left hand; etc. (medical description).		
	Date of Injury:	Time:	Working shift: from to
15.	Was employee able to continue work after the injury? Yes _____		If no, date left work:
	(b) Has employee returned to work?	(c) If so, give date.	
	(d) If not, probable length of disability:	(e) Did injury/illness force employee to transfer to a different assignment?	
16.	Date of last job-related injury/illness:		
17.	Prepared by: (employee signature)		Date:

Read Carefully

Effective July 1, 1990, SECTION 1. 8-43-102, Colorado Revised Statutes, 1986 RepI. Vol., as amended by House Bill **90-1160**, enacted at the Second Regular Session of the Fifty-seventh General Assembly, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

8-43-102. Notice to Employer of injury - failure to report. (1.5) (a) Every employee of an employer who has permission to be its own insurance carrier pursuant to section 8-44-201 or of an employer who participates in a public entity self insurance pool pursuant to section 8-44-204 who sustains an injury resulting from an accident shall notify his employer in writing of said injury within four working days of the occurrence of the injury, unless the employer, or the employee's foreman, superintendent, or manager has written notice of said injury. If the employee is physically or mentally unable to provide said notice, the employee's foreman, superintendent, or manager, or any other person in charge who has written notice of said injury, shall submit such written notice to the employer. If said employee fails to report said injury in writing, such employee may lose up to one day's compensation for each day's failure to so report. Any other person who has notice of said injury may submit a written notice to the employer which report shall relieve the injured employee from reporting the accident. Any employer receiving written notice of an injury pursuant to this subsection (1.5) shall affix thereon the date and time of receipt of such notice and shall make a copy of such notice available to the injured employee within two working days following receipt of such notice.

INSTRUCTIONS TO EMPLOYEE

1. All iniuries, no matter how trivial, must be reported to your employer.
2. Forms should be typed or printed legibly.
3. Instructions for Question 9:
If an accident/exposure occurred on employer's premises, give address of plant or establishment in which it occurred. If it occurred outside employer's premises at an identifiable address, give that address. If it occurred on a public highway or at any other place which cannot be identified by number and street, please provide place references locating the place of accident or exposure as accurately as possible.

INSTRUCTIONS To EMPLOYER

1. You must complete an Employer's First Report of Injury and send it along with this form to the pool's claims administrator.
2. You must note the date and time of receiving this notice from the employee in the space provided below.
3. You must provide a copy of this complete Employee's Notice of Injury to the employee within two working days

EMPLOYER'S ACKNOWLEDGEMENT OF RECEIPT OF EMPLOYEE'S NOTICE OF INJURY

Completed form received from employee on _____ at _____ am/prn
(date)

by: _____
employer representative

completed copy of this form provided to employee on _____
(date)

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INJURY REPORT PART 2 - Supervisor

Report # _____

Supervisors Accident/Incident Report

Colorado Special Districts Property & Liability Pool

Note to Employer: It has been established that accidents cost the employer directly approximately four times the amount of compensation, liability and medical expenses.

1. Name & District (Supervisor Only to make out Report)

City and State

2. Location of Accident

3. Date of Accident

4. Hour of Accident

AM PM

5. Name of Injured Employee

6. Date of Hire

7. What were Injured's Duties?

8. Fully Describe the Nature of the Accident (below)

() Circle causes of accident below: Accident causes

***Other Reason:** _____

A. Instructions

- (A) None (B) Not Enforced
(C) Incomplete (D) Erroneous

A. Physical Hazards Lie!. Mechanical, Electrical,
Steam Chemical Conditions, etc.

- (A) Ineffectively Guarded
(B) Unguarded

B. Ability of Employee

- (A) Inexperience (B) Unskilled
(C) Ignorance (D) Poor Judgment

B. Housekeeping

- (A) Improperly Piled or Stored Material
(B) Congestion

C. Discipline

- (A) Disobedience of Rules
(B) Interference by Others
(C) Fooling

C. Equipment

- (A) Defective Tools
(B) Defective Machines
(C) Defect of Misc. Materials & Equipment

D. Concentration to Job

- (A) Attention Distracted
(B) Inattention

D. Unsafe Conditions

- (A) Fire Protection (B) Exits
(C) Floors (D) Openings
(E) Miscellaneous (F) Weather

- E. Unsafe Practices
 - (A) Chance Taking
 - (B) Short Cuts
 - (C) Haste

- E. Poor Working Conditions
 - (A) Poor Ventilation
 - (B) Inadequate Sanitation
 - (C) Inadequate Light
 - (D) Excessive Noise

- F. Temperament
 - (A) Sluggish or Fatigued
 - (B) Violent Temper
 - (C) Excitability

- F. Workplace Hazards
 - (A) Layout of Operations
 - (B) Layout of Machinery
 - (C) Unsafe Processes

- G. Physical Condition
 - (A) Fatigued
 - (B) Weak
 - (C) Taking Medication

- G. Dress or Apparel
 - (A) No Goggles, Gloves, Masks, Etc.
 - (B) Unsuitable, Long Sleeves, Etc.
 - (C) Shoes/Boots, Defective, Etc.

10. What recommendation can you make to eliminate above cause(s) of accident?

11. Have you communicated the accident prevention recommendations from #10 to other crew members and supervisors within the district? Yes No

12. Did you send injured to first aid room? (If answered "Yes" we assume that you checked up to see that injured employee actually received treatment) Yes No

Signature of Supervisor: _____

Date: _____

Print Name: _____

13. My signature below indicates only that I have read and understand the above information, however, my signature does not necessarily indicate agreement with its contents.

Signature of Employee : _____

Date: _____

Print Name: _____

Comments:
