DESIGNATED PROVIDER NOTIFICATION

At **Montezuma-Cortez School District Re-1** we provide our employees with the highest level of care in the event of a work-related injury or illness. We are in the process of filing a claim with our workers' compensation insurance carrier, CopperPoint. A representative from CopperPoint will contact you with a claim number and any additional information very soon. In the meantime, you should see one of the medical providers we have selected to treat our employees when a work-related injury and/or illness occurs. These medical providers specialize in on-the-job injuries and illnesses, and we want that high level of care for you. Our providers are:

SMG School-Base Clinic **418 S Sligo** **Cortez, CO 81321** **970-564-4855**
Southwest Memorial Walk In Clinic **1413 N Mildred Road** **Cortez, CO 81321** **970-564-1037**
Southwest Memorial Primary Care **1311 A N. Mildred Road, Suite D** **Cortez, CO 81321** **970-565-8556**

In the unfortunate event of a life–or-limb-threatening emergency, you will certainly be sent to the nearest emergency medical facility. However, one of the medical providers designated above **must** provide all follow-up care.

For non-emergency injuries, please select one of the providers and see them as soon as possible. After your first appointment, please follow up with me, so we can review your medical status and work capabilities together.

If you have any questions, please contact me. Our goal is to ensure that you receive the highest level of care and recover quickly and return to work as soon as possible.

Company Contact Information
Cynthia Eldredge
400 N. Elm/PO Drawer R
Cortez, CO 81321
970-565-7282 ext. 1135
Workers Compensation Insurance contact information
CopperPoint
3030 N 3rd Street
Phoenix, AZ 85012-3068
602.631.2300 or 800.231.1363

Delivered _____

Employer Signature _____

Employee Signature _____

TREATMENT ADVISORY

I (name of injured)_____, do hereby acknowledge that I have been informed of my choice of designated providers by (name of supervisor)_____, as well as the importance of medical evaluation and treatment for my work-related injury and/or illness which occurred on (date)_____. I have made the clear and conscious decision to refuse any medical treatment for any injuries and/or illnesses resulting from this event. I further acknowledge that should I need treatment later for this work-related injury and/or illness that I will notify my employer and seek treatment with one of the designated providers I was given.

_____ _____
Employee Signature Date

_____ _____
Supervisor Date

See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY

Employee's name (first, middle, last)	Social Security #	☐ Male ☐ Female	Employee's home phone # ( )	OSHA Log #
Employee's street address	City	State	Zip code	

Birth date / /	Marital status ☐ Married ☐ Separated ☐ Single ☐ Unknown	Date of hire / /	Occupation	Employment status ☐ Full time ☐ Part time ☐ Other ☐ Unknown	For Division use only

Employer's name: Montezuma-Coretz School District Re1	Employer's Federal ID # 84-0525195	Employer's phone #	SOI
Employer's mailing address	City	State / Zip code	POB
Average weekly wage at time of injury $_____ (see instructions on reverse side)	Check box if employee receives ☐ Tips ☐ Meals ☐ Room ☐ Health insurance	Check if these benefits are included in AWW ☐ Tips ☐ Meals ☐ Room ☐ Health insurance	NOI / Coder
Is the employer self-insured? ☐ Yes ☒ No	Were full wages paid for the DOI? ☐ Yes ☐ No	Are wages continued per C.R.S. 8-42-124? [1] ☐ Yes ☐ No	

Injury/Illness date / / (See instructions on reverse side)	Time employee began work ____ ___ ☐ a.m. ____ ___ ☐ p.m.	Injury time ____ ___ ☐ a.m. ____ ___ ☐ p.m. ☐ unknown	Last day worked / /	Date employer notified / /	Date disability began / /	Date returned to work / /

Did injury cause death? ☐ Yes ☐ No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death	Injury occurred because of ☐ Intoxication ☐ Safety violation ☐ Not applicable

Tell us the part of body that was affected	Tell us the nature of the injury/illness[2]
What was the employee doing just before the accident occurred?[3]	
Tell us how the injury occurred[4]	What object or substance directly harmed the employee? [5]

Did injury occur on premises? ☐ Yes ☐ No	Injury site address/ 9-digit zip code	Initial treatment (check one) ☐ None ☐ Emergency room ☐ Minor on-site ☐ Hospital >24 hrs ☐ Clinic/hospital	Was the employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Names of witnesses	Name of employer representative notified
Name and address of treating doctor or other health care professional	Name and address of facility where treated

Completed by (name)	Title	Phone # ( )	Date completed / /

The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.

Name of insurance company Copperpoint Insurance Companies	Address
Name of third party administrator (if applicable)	Address
Adjuster name	Adjuster phone #

Policy # 1020922	Carrier claim #	Date insurer received first report / /	Block #	Adj. Code

INSTRUCTIONS
This form contains all items requested on OSHA Form No. 301,
"Injuries & Illnesses Incident Report"

General

- All injuries, no matter how trivial, must be reported to your insurance company.
- All injuries or occupational diseases which result in lost time from work more than three shifts or calendar days, or in permanent physical impairment, must be reported to your insurance carrier on this form within ten days after notice or knowledge of the injury or disease. Fatalities must be reported to your insurance carrier immediately.
- Forms should be typed or printed legibly. All questions must be answered completely to meet the requirements of the Colorado Workers' Compensation Act and to conform to the OSHA requirements for Form No. 301.
- The employer has the right in the first instance to select the physician who attends to the injured employee.

Calculation of Average Weekly Wage

- Determine the weekly wage rate.
- Add the average weekly amount of any overtime wages, tips, or commissions.
- Add the average weekly value of any board, rent, housing, or lodging provided by the employer *if the employer will not be paying such benefit during the period of disability.*
- If the employee is covered by group health insurance *and* the employer does not continue the employee's health insurance coverage during the period of disability, add the employee's cost of conversion to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Compute the total from the above categories and insert in the *Average weekly wage at time of injury* field.

Injury Date Information

In the case of an occupational disease, use the date of the last injurious exposure.

Notes

Are Wages continued per C.R.S. 8-42-124?[1]

(Subject to application with and approval of the Director of the Colorado Division of Workers' Compensation)

1 Any employer who, by separate agreement, working agreement, contract of hire, or any other procedure, continues to pay a sum in excess of the temporary total disability benefits to an employee temporarily disabled as a result of a work related injury or disease**,** and has not charged the employee with any earned vacation leave, sick leave, or other similar benefits, shall be reimbursed if insured by an insurance carrier or shall take credit if self-insured, to the extent of all moneys that such employee may be eligible to receive as compensation for temporary partial or temporary total disability subject to the approval of the Director of the Colorado Division of Workers' Compensation.

Injury Description (Tell us the part of body that was affected. Tell us the nature of the injury/illness [2]; What was the employee doing just before the accident occurred? [3]; What happened? [4]; What object or substance directly harmed the employee?[5])

2 Be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

3 Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."

4 Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

5 Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.

Notices

You are hereby notified that if a child support obligation is owed, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S. YOU ARE FURTHER NOTIFIED that you must provide written notice of any award for social security, pension, disability, or other source of income that might reduce your compensation benefits. This notice must be sent to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in suspension of your benefits pursuant to section 8-42-113.5, C.R.S.

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 for the purposes of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant regarding a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

Employee Accident Report

Any work-related injury and/or illness must be reported to a supervisor immediately, per company policy. This form shall be completed by the injured worker and reviewed by the supervisor, and saved for company records.

Employee Name:_____ **Position:** _____

Date of Injury: _____ **Time:** _____

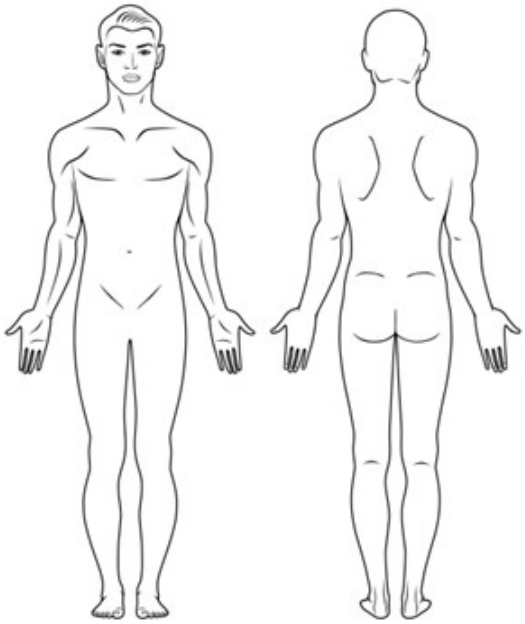
Supervisor name: _____ **Location:** _____

☐Designated Provider List received

Briefly Describe the Injury and/or Illness AND How it Occurred: _____

Supervisor notes:_____

Body Part Injured:



Recommendations to Avoid Future Incident: _____

By signing below, I confirm that all the information provided here and on any attachments is complete and true to the best of my knowledge, and that my supervisor has reviewed the information contained within.

_____ _____

Employee **Date**

_____ _____

Supervisor **Date**

SUPERVISOR INCIDENT AND/OR ACCIDENT INVESTIGATION

Injured Employee: _____ Position: _____

Date of Injury: _____ Location: _____

Time: _____ Witnesses: _____

Time Work Began: _____ Last Day Worked: _____

Incident and/or Accident Details:

Employee Description of Incident: _____

_____

_____

_____

_____

Supervisor Description of Incident: _____

_____

_____

_____

Root Cause: _____

_____

_____

_____

_____

Recommendations: _____

_____

_____

_____

_____ _____ _____

Supervisor **Department** **Date**