



# FIRST REPORT OF INJURY

**INSTRUCTIONS:** Please complete the following information. If you do not know specific information, just leave it blank. This statement should be returned to Human Resources, (Campus Box 47, Fax 6-5151) within 48 hours of injury date.

## A. Critical Information

Employee Social Security Number: \_\_\_\_\_  
Employee Name: \_\_\_\_\_ SEX: M F (Circle One)  
Last First MI  
Policy #: 1244  
Company Name: Metropolitan State College of Denver  
Company Address: CB 47, PO Box 173362, 1201 5<sup>th</sup> Street, Suite 510, Denver, CO 80217-3362  
Entered by: Benefits Administrator  
Phone: 303.556.3120 E-Mail Address: kmoore65@mscd.edu

## B. Injured Employee Information

Employee Home Phone: \_\_\_\_\_ Employee Date of Birth: \_\_\_\_\_  
Employee Home Address: \_\_\_\_\_  
Employee City / State / Zip: \_\_\_\_\_  
Employee Language: \_\_\_\_\_ Employee Marital Status: \_\_\_\_\_

## C. Wage / Work Information

Employee's Supervisor Name: \_\_\_\_\_ Supervisor Phone: \_\_\_\_\_  
Employee's Title: \_\_\_\_\_ Hire Date: \_\_\_\_\_  
Days Worked in Week: \_\_\_\_\_ Hours Worked in Week \_\_\_\_\_  
Monthly/Hourly Wage Rate: \_\_\_\_\_  
Returned to Work: Yes / No (Circle One) Date Returned to work: \_\_\_\_\_  
Employee Work Phone: \_\_\_\_\_ Employee Work Schedule: M\_\_ T\_\_ W\_\_ Th\_\_ Fr\_\_

## C 2. Policy Designations

Department: HE – DEPARTMENT OF HIGHER EDUCATION  
Division: HEME – METROPOLITAN STATE COLLEGE OF DENVER

## D. Accident Information

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_  
Accident Location: \_\_\_\_\_  
Time Work Began: \_\_\_\_\_  
HR Rep Notified (Print Name): \_\_\_\_\_ Employer Rep Phone: 303.556.3120

## E. Medical Information

Did you receive treatment? Yes / No (Circle one)  
Provider Name: \_\_\_\_\_  
Body Parts Injured: \_\_\_\_\_  
How did this Accident Occur?: \_\_\_\_\_  
\_\_\_\_\_  
Was 911 called? Yes / No (Circle One) Minor –Clinic? Yes / No (Circle One)  
Admitted to Hospital? Yes / No (Circle One) Emergency Room? Yes / No (Circle One)  
Surgery? Yes / No (Circle One)

## F. Witness Information

Witness Name: \_\_\_\_\_ Witness Phone: \_\_\_\_\_  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
Employee/Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

