**PINNACOL ASSURANCE**

**First Report of Injury**

To Report a Claim:

Call 303-361-4000 or 800-873-7242

Or Fax to 303-361-5500 or 888-329-2251

Or, go to [www.pinnacol.com](http://www.pinnacol.com)

**Early reporting can save you money. Report all injuries IMMEDIATELY!**

The information below allows Pinnacol Assurance’s customer service representatives to quickly and accurately process your claim. Use the completed form as a guide when reporting by phone or online to save you time. Don’t wait to report if you don’t have all the answers.

**POLICY INFORMATION**

Policy Number: 4044224 Business Name: San Luis Valley BOCES

Business Address: 2261 Enterprise Drive, Alamosa, CO 81101 Fax: 719-589-5007

Prepared By: Staci Turner, Business Manager Phone: 719-587-5405 Email: sturner@slvboces.org

Date Completed:

**INJURED WORKER INFORMATION**

Injured Worker’s Social Security Number: Date of Injury:

First Name: M.I.: Last Name:

Home/Mailing Address:

Phone Number(s): Email:

Date of Birth: \_\_M\_\_F \_\_Other Marital Status:

Language:

Occupation: Date Hired:

\_\_Full-Time \_\_Part-Time \_\_Seasonal \_\_Volunteer \_\_Independent Contractor

Days Worked per Week: Hours Worked Per Day:

Pay Rate: \_\_Hourly \_\_Weekly \_\_Monthly \_\_Annually \_\_Other

**ACCIDENT/INJURY INFORMATION**

Fatal Injury: \_\_Yes \_\_No If Fatal Injury: Date of Death

Time of Injury: Time Work Began: Last Day Worked:

Full Pay on Date of Injury: \_\_Yes \_\_No

Did Accident Occur on Employers Premises: \_\_Yes \_\_NO

Accident Location:

Name of Employer Representative(s) Notified:

Date & Time Employer Representative(s) Notified:

Witnesses (Name & Phone Number):

How Did the Injury Occur?

Specific Activity the Employee was Engaged In:

What Equipment was Being Used:

Body Parts Injured (Be Specific):

Type of Injury Sustained:

\_\_Safety Equipment Provided \_\_Safety Equipment Used

\_\_Possible Drug/Alcohol Involved \_\_Employer Questioning Liability

**RETURN TO WORK INFORMATION**

Has the Injured Worker Returned to Work? \_\_ Yes \_\_NO

Date Returned to Work: Estimated Return to Work Date:

Is this a lost time Claim? \_\_ Yes \_\_No (Claim is lost time if there is a loss of more than three scheduled work days to the injury)

**MEDICAL PROVIDER INFORMATION: Where Was Your Employee Treated?**

\_\_NO Medical Treatment \_\_Treated by Employer \_\_911 Called \_\_Walk-In Clinic

\_\_Emergency Room \_\_Hospitalized > 24hrs/Overnight \_\_Possible Surgery

Medical Provider Name/Address/Phone Number: