WORKER'S COMPENSATION

RULES AND REGULATIONS

The compensation company for Montezuma County is:

County Workers' Compensation Pool
800 Grant Street, Suite 400
Denver, CO 80203

1-800-544-7868

IF INJURED ON THE JOB GO TO:

Southwest Internal Medicine
Karla Demby, MD
Erin Henderson, MD
Cortez, CO 81321
970-564-8730

Colorado Senate Bill 218 provides that the injured employee must give written notice to employer WITHIN 4 DAYS OF THE OCCURRENCE OF THE INJURY. If the employee is physically or mentally unable to provide notice, the employee's foreman, superintendent, manager or any other person in charge who has notice of injury must submit written notice to the employer. The statute further states, "any other person who has notice of said injury may submit a written notice to the said person in charge or to the employer, and in that event the injured employee shall be relived of the obligation to give such notice."

The employer in turn should submit claims to the comp company within 24 hours of the employee's written notice of injury to the employer.

The comp company has only 14 days from the date the employee provides written notification to the employer to begin compensation benefits.

The Division of Workers' Compensation may impose a penalty against the EMPLOYER of $500 per day for violation of the notification process. If the injured EMPLOYEE fails to report the injury in writing, he/she may LOSE UP TO ONE DAY'S COMPENSATION FOR EACH DAY'S FAILURE to do so. (It is a good idea to date stamp the first Report of Injury.)

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 in excess of 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 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 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 with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

Clear Entire Form

See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

NCCI Code _____
Cost Center Code_____

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	Employer's Federal ID #	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 ☐ Minor on-site ☐ Clinic/hospital ☐ Emergency room ☐ Hospital >24 hrs	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 **County Technical Services Inc.**	Address **800 Grant St., Suite 400, Denver, CO 80203**
Name of third party administrator (if applicable)	Address
Adjuster name	Adjuster phone # **(800) 544-7868 (303) 861-0507**

Policy # **CWCP**	Carrier claim #	Date insurer received first report / /	Block # **801**	Adj. Code **CY**

Supervisor's Accident/Incident Report

Complete this form in its entirety and send to:
CTSI Loss Prevention
800 Grant St., Suite 400, Denver, CO 80203

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. County (Supervisor Only to make out Report) City and State 2. Location of Accident
MONTEZUMA COUNTY

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

I. Unsafe Practices

A. Instructions
(A) None (B) Not Enforced
(C) Incomplete (D) Erroneous

B. Ability of Employee
(A) Inexperience (B) Unskilled
(C) Ignorance (D) Poor Judgment

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

D. Concentration to Job
(A) Attention Distracted
(B) Inattention

II. Unsafe Condition

A. Physical Hazards Incl. Mechanical, Electrical, Steam Chemical Conditions, etc.
(A) Ineffectively Guarded
(B) Unguarded

B. Housekeeping
(A) Improperly Piled or Stored Material
(B) Congestion

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

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 county? 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:

14. 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:

Comments:

County Workers' Compensation 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: **MONTEZUMA COUNTY**		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).		
14.	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:

Employee and Employer: See Reverse Side for Important Notice

CTSI

Form prepared by County Technical Services Inc. 7/90, 12/93, 1/97

READ CAREFULLY

Effective July 1, 1990, SECTION 1. 8-43-102, Colorado Revised Statutes, 1986 Repl. 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 injuries, no matter how trivial, must be report 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/pm
(Date)

By: _____
Employer representative

Completed copy of this form provided to employee on _____.
(Date)

Montezuma County
Workers' Compensation Designated Medical Provider List

When an employee is injured on the job it must be reported immediately so to assure quality medical care is provided in a timely manner. The first priority after an injury is to get appropriate medical care. If your work related injury requires emergency response; if you are transported to the nearest medical facility, or if the injury occurs after normal business hours or on a weekend, you ***must follow up with one of our designated workers' compensation providers as soon as possible***. Also, please call the county's workers' compensation claim contact immediately to report the injury and address any questions. The county's contacts are as follows:

Contact	Billye Morgan
Title	Human Resource Assistant
Mailing Address	109 West Main St., room 302
City, State Zip	Cortez, CO 81321
Email	bmorgan@co.montezuma.co.us
Phone	970-565-8317
Fax	970-565-3420

Contact	Faedra Grubbs
Title	Finance Officer
Mailing Address	109 West Main St., room 302
City, State Zip	Cortez, CO 81321
Email	fgrubbs@co.montezuma.co.us
Phone	970-565-8317
Fax	970-565-8317

Your county has designated primary care providers who will direct all medical care for injured employees. Employees should not seek care from other providers unless it is an emergency. The designated providers are:

Name of Physician//Medical Provider	Southwest Internal Medicine – Dr. Demby, Dr. Henderson, Dr. McAlpin
Location Address	111 N. Park, Suite 1
City, State Zip	Cortez, CO 81321
Phone	970-564-8730
Hours	Monday thru Friday 8:00 a.m. –5:00 p.m

Name of Physician//Medical Provider	
Location Address	
City, State Zip	
Phone	
Hours	

Name of Physician//Medical Provider	
Location Address	
City, State Zip	
Phone	
Hours	

Name of Physician//Medical Provider	
Location Address	
City, State Zip	
Phone	
Hours	

Please choose ***one*** of the designated providers with whom you will treat. You may choose ***any*** of these providers. On occasion another provider in the office may see you if you make an appointment on short notice or if your designated provider is unavailable. However, you must resume seeing your designated provider for all subsequent visits.

Your county's workers' compensation claims are administered by County Technical Services, Inc. (CTSI). All reasonable and necessary, authorized treatment related to your injury will be paid. You will also be reimbursed for mileage to and from medical or therapy appointments. Medical providers should mail claims (bills) to: CTSI Workers' Compensation Department, 800 Grant St., Suite 400, Denver, CO 80203. Phone: (303) 861-0507 or (800) 544-7868. Fax: (303) 861-1022. Carole Dinan-Fitch is the Workers' Compensation Claims Manager for CTSI.

I, the below named county employee, acknowledge receipt of this designated medical provider list.

Employee Printed Name _____ Date _____

Employee Signature _____ Workers' Compensation Representative _____