

CSU WORKERS' COMPENSATION FIRST REPORT OF INJURY

(complete paper copy only if no internet access and report can not be filed at

<http://rmi.colostate.edu/workers-compensation/file-an-incident/>

Incident, Injury, Illness, Exposure

Employee Name (include first and last name)

Incident Date

Incident Time

Are you an Employee of CSU?

Were you injured during paid work duty?

Department employee was working for at time of incident

Employment Classification (100% State
Classified, 50% AP, Hourly, etc)

What is employee's position title?

Please describe employee's normal job duties

Hours Worked Weekly

Supervisor Name

Supervisor Email Address

Supervisor Work Phone Number

Location of Incident

Reporting Person's Relationship to Employee

Has employee been taken off work by a
medical professional due to injury?

Employee Information

CSU ID Number

Employee Mailing Address 1

Employee Mailing Address 2

Employee Mailing City

Employee Mailing County

Employee Mailing State

Employee Mailing Zip Code

Employee Mailing Country

Best Contact Phone Number for Employee

Employee Home Phone	
Employee Work Phone	
Employee Preferred Email	
What is employee's normal work location?	

Incident Details.

Please describe, in detail, what activities were performed, what happened to cause incident and what injury resulted.

Body Part Injured Description/Side of Body Injured (if applicable)	
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Are there any prior injuries or recent surgeries to the injured area?	
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Were normal job duties being performed at time of incident?	
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Are there any special circumstances surrounding this incident?	
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Please list safety concerns or action items that can be addressed to prevent this type of incident in the future

Were any of the following materials involved: **(IF NO, PLEASE SKIP TO PAGE 4)**

Hazardous or Regulated Materials, Select Agents, pathogens
containing recombinant DNA or synthetic nucleic acid
molecules?

Actions Taken After Event

- ☐ Called Emergency Services
- ☐ Cleaned Spill
- ☐ Cleaned/Rinsed Injury
- ☐ Completed Required Department Reports
- ☐ Evacuated Area
- ☐ Informed Supervisor
- ☐ Other (please describe)
- ☐ Preventative actions immediately taken to protect others from injury/illness (please describe)
- ☐ Sought First Aid

Factors involved in incident

- ☐ Animal – involving direct contact or work with an animal
- ☐ Biological – having to do with biological materials or agents
- ☐ Biological and/or Animal Work in a Biosafety Level 1, 2, or 3 Facility
- ☐ Chemical/Radiation – involving chemicals or radioactive materials
- ☐ Environmental – involving an environmental factor such as heat, cold, wet/damp conditions, ice, wind etc.
- ☐ Other
- ☐ Physical – involving the physical environment such as equipment, building components, sidewalks, etc.
- ☐ Protocol/Procedure – having to do with protocols or procedures not being followed
- ☐ Report Only
- ☐ Sharp/Needle - involving direct contact or work with sharp object or needle

Personal Protective Equipment

Personal Protective Equipment (PPE) Used?

Treatment Information

Was 911 Called?

Did employee seek medical treatment? If so, where? (Pls. list provider, address, and phone number)

Were there any witnesses to the incident?

Date Report Completed: _____

After completion, please:

e-mail to: workcomp@colostate.edu

OR

FAX to: 970-491-4804

OR

Interoffice Mail: 6002 Campus Delivery