# Workers' Compensation Claims Packet

# ELLICOTT SCHOOL DISTRICT 22

**Designated Provider List Notification Letter**
**For An Injured Worker**

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**To:** _____

**From:** **Ellicott School District - HR**

**Date:** _____

**Subject:** Designated Provider List Notification Letter for an Injured Worker

I am sorry to learn that you have been injured. To make sure you receive the care you need, we are filing a claim with our workers' compensation insurance carrier, Pinnacol Assurance. Pinnacol will contact you with your claim number and additional information. In the meantime, you should see one of the medical providers we have selected to treat our injured employees. These medical providers specialize in on-the-job injuries, and I want you to have the best possible care.

**1. Name:** Concentra Medical Center-North
**Address:** 5320 Mark Dabling Blvd Ste 100
**City, State & Zip:** Colorado Springs CO 80918
**Phone:** 719-592-1584

**2. Name:** UC Health Occupational Health Clinic
**Address:** 11605 Meridian View Ste 184
**City, State & Zip:** Falcon, CO 80831
**Phone:** 719-364-9561

**3. Name:** Concentra Medical Center-South
**Address:** 2322 S Academy Blvd
**City, State & Zip:** Colorado Springs CO 80916
**Phone:** 719-390-1727

**4. Name:** Colorado Occupational Medical
**Address:** 3910 S Carefree Cir Ste B
**City, State & Zip:** Colorado Springs CO 80917
**Phone:** 719-457-6001

Please contact one of these medical providers to be seen as soon as possible. After your first appointment, please follow up with me so we can review your medical status and work capabilities.

The respondent's representative is our workers' compensation insurance company, Pinnacol Assurance. Please see the contact information below.

Pinnacol Assurance
7501 E. Lowry Blvd.
Denver, CO 80230-7006
303.361.4000 or 800.873.7242

If you have questions, please contact me. My goal is to ensure that you get the care you need to recover quickly and return to work as soon as possible.

**Organization Name and Phone:** **Ellicott School District** - 719-683-2700

**Address:** 322 S Ellicott Hwy

**City, State & Zip:** Calhan CO 80808

**Employer's Representative for Workers' Compensation:**

**Name:** Lexi Van Patten- HR

**Phone:** 541-954-7671

☐ Hand-delivered on:_____

☐ Mailed to injured worker on:_____

_____

**Employer's signature**

_____ _____

**Employee's signature** **Date**

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

# EMPLOYER'S FIRST REPORT OF INJURY

| Employee's name (first, middle, last) | Social Security# | D Male D Female | Employee's home phone# ( ) | OSHA Log# |
|---|---|---|---|---|
| Employee's street address | City | State | Zip code | |
| Birth date / / | Marital status D Married D Separated D Single D Unknown | Date of hire / / | Occupation | Employment status D Full time D Part time D Other D Unknown | For Division use only |
| Employer's name: Ellicott District 22 | Employer's Federal ID#84-6001187 | Employer's phone# | SOI |
| Employer's mailing address 322 S Ellicott Hwy | City Calhan | State CO | Zip code 80808 | POB |
| Average weekly wage at time of injury $ | Check box if employee receives D Tips D Meals D Room D Health insurance | Check if these benefits are included in AWW D Tips D Meals D Room D Health insurance | NOi / Coder |
| Is the employer self-insured? D Yes x No | Were full wages paid for the DOT? D Yes D No | Are wages continued per C.R.S. 8-42-124? [1] D Yes D No | |

| Injmy/Illness date / / (See illustrations on reverse side) | Time employee began work ____ a.m. ____ p.m. | Injury time ____a.m. ____p.m. o unknown | Last day worked / / | Date employer notified / / | Date disability began / / | Date returned to work / / |
|---|---|---|---|---|---|---|

| Did injury cause death? D Yes D 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? D Yes D No | Injury site address/ 9-digit zip code | Initial treatment (check one) D None D Emergency room D Minor on-site D Hospital >24 hrs D Clinic/hospital | Was the employee hospitalized overnight as an in-patient? D Yes D 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 Pinnacol | Address 7501 E Lowery Blvd Denver CO 80230-7006 |
|---|---|
| Name of third party administrator (if applicable) | Address |
| Adjuster name | Adjuster phone # |
| Policy# 4244743 Carrier claim # | Date insurer received first report Block# Adj. Code |