INSTRUCTIONS/INFORMATION FOR INJURED EMPLOYEES

1. We want recovery to be as swift as possible, and we will work with all employees to reach that goal. **Durango School District 9-R ("9-R")** will provide transitional duty within ANY restrictions the doctor provides.

2. 9-R requires that any **employee** who has had a work-related incident resulting in illness/injury **MUST report the incident IMMEDIATELY to their supervisor**.

3. **In the event of a life or limb emergency, the injured employee will be sent to the nearest emergency medical facility. The medical providers listed below must provide follow up care.**

   If non-emergency medical treatment is needed, the injured employee must go to one of the following three (3) designated medical providers.

   - **Animas Urgent Care**, 450 S. Camino del Rio #106; Telephone 970-**385-2388**; (located across from Bodo Park; sign states URGENT CARE)
     8:30 AM to 7:00 PM, seven days a week

   - **Centura Centers for Occupational Medicine - CCOM Durango,** 810 East 3rd St., Suite 202; Telephone 970-**764-9850** (located in the Horse Gulch Medical Campus)
     8:00 AM to 5:00 PM, Monday - Friday

   - **La Plata Family Medicine,** 316 Sawyer Dr.; Telephone 970-**259-3110 – you must ask for the Worker's Comp Physician if you use this facility.**
     (located in Bodo Park; turn right on Sawyer Drive; the traffic light located @ Durango Mall
     8:00 AM to 7:00 PM, Monday – Thursday
     8:00 AM to 5:00 PM, Friday
     9:00 AM to 5:00 PM, Saturday

Under the Workers' Compensation Law, 9-R may select your treating physician. Seeing another doctor without approval is unauthorized, and will result in non-payment by the insurance company. If the injured employee receives emergency medical care, they must still follow-up with one of the appointed doctors listed above.

4. **When any incident requires medical treatment, 9-R requires the supervisor to notify the Workers' Compensation Coordinator immediately – submit the Employee Accident Report immediately so we may start the claim**. Otherwise, treatment may not be authorized and the employee may be liable for payment of related medical expenses. The employee must complete the attached **Employee Accident Report** and provide it to his/her supervisor or supervisor's designee**,** and the supervisor must complete the attached **Supervisor's Accident Investigation Report**.

5. **The complete Accident Report Packet must be filed with the Workers' Compensation Coordinator within two (2) business days of the incident, or loss-of-benefits may occur. It is the supervisor's responsibility to file the Accident Report Packet. That packet includes**:

- Employee signature form for the information/instructions
- Employee Accident Report
- Supervisor's Accident Investigation Report

6. There are forms that must be completed at each doctor visit. Before the injured employee leaves the doctor's office they must receive the form that specifically indicates any activity restrictions, if applicable. The completed form is to be submitted to the Workers' Compensation Coordinator in the Human Resources Office, or faxed to 970-**385-3643**.

7. The Workers' Compensation Coordinator, and the injured employee's supervisor, must be notified of the time and date of each clinic appointment. If an appointment is cancelled, the injured employee must notify the Workers' Compensation Coordinator, and his/her supervisor as soon as possible and reschedule the appointment within 24 hours. **The injured employee may not miss work for a workers' compensation injury without an examination and authorization note from the medical provider.**

8. The injured employee is to schedule follow-up medical or physical therapy appointments outside of work hours. Contact the Workers' Compensation Coordinator if there are any issues with this.

9. A nurse from Pinnacol Assurance may be in contact with the injured employee by telephone or in person.

10. All medical bills from physician, pharmacies, etc. must be submitted to the Workers' Compensation Coordinator (see contact information below).

11. Failure to follow these workers' compensation injury instructions may involve disciplinary action which may include termination.

12. The Workers' Compensation Coordinator at the district may be contacted through the Human Resources Office located at 201 E. 12th Street, Durango, CO 81301, by phone 970-247-5411 x 1438, by fax 970-385-3643, or by email to lgalido@durangoschools.org

After Reading the above information, please initial to the statement below:

______ I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE INFORMATION STATED ABOVE, AND THAT I HAVE BEEN PROVIDED A LIST OF THE DESIGNATED PROVIDERS.

If you are not seeking treatment at this time, please initial to the statement below:

______ I HAVE BEEN OFFERED MEDICAL TREATMENT, BUT DO NOT PLAN TO SEEK TREATMENT AT THIS TIME.

____ ____________________

EMPLOYEE SIGNATURE DATE

____ ____________________

WITNESSING SUPERVISOR / DESIGNEE SIGNATURE DATE

Please ensure the employee receives a copy of the Instructions/Information for Injured Employees, a copy of their completed Employee Accident Form, and the one page sheet with further detail regarding the Designated Providers for Workers' Compensation.

EMPLOYEE ACCIDENT/INJURY/NEAR MISS REPORT – to be completed by injured

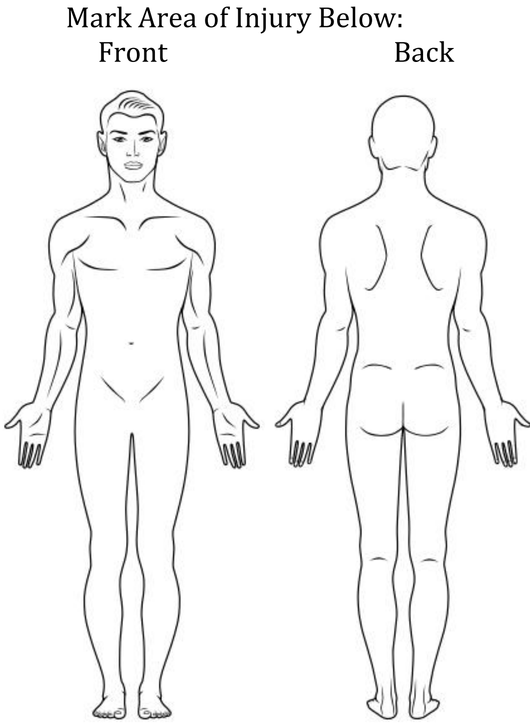
Please print clearly. Complete within 24 hours of accident/injury/near miss.

Location: ___________________________ Reported to Work:________ a.m. p.m.
Last name: __________________________ First name: _________________ M.I. _____
Address: ____
City: ___________________ State: _______ Zip: _______ Phone #:__________________
Injury/near miss date: __________ Time: ______ a.m. p.m. Left work: ______ a.m. p.m.
Returned:_________ a.m. p.m.
Lost time: (check one) Yes____ No____
Employee's explanation for injury/near miss: _____________________________________
____
____
____
Date supervisor notified: ________________ Date report completed: ________________
Supervisor's name: _____________________________________
Name of witness to accident: _________________________________
Was there a: □ Safety violation □ Machine malfunction □ Motor vehicle
Employee's recommendation to prevent reoccurrence: ______________________________
____
____

Cause
□ Slip & Fall
□ Struck by equipment
□ Lifting or moving
□ Caught (in, on or between)
□ Needle puncture
□ Object in eye (Right or Left or Both)
□ Repetitive/overuse
□ Other: ____________

Type of Injury
□ Scrape/bruise
□ Sprain/strain
□ Puncture wound
□ Cut/laceration
□ Concussion
□ Bite
□ Chemical burn/rash/breathing difficulties
□ Other: ___________
□ No apparent injury

Mark Area of Injury Below:
Front Back



Employee referred to: □ Designated Provider □ Hospital/ER □ Refused to see medical provider
Designated Provider employee is seeing: ____
Supervisor's Signature: _________________________________ Date:____________
Employee's Signature: ___________________________________ Date: _____________

Rev. 7/26/16; Updated 12/28/16; Updated 7/31/17; Updated 7/11/18; Updated 7/18/19

WORKERS' COMPENSATION
DESIGNATED PROVIDERS LIST

ANIMAS URGENT CARE
450 S. Camino Del Rio, #106
Durango, CO 81301
970-385-2388
Across from Bodo Park, sign states URGENT CARE

CENTURA CENTERS FOR OCCUPATIONAL MEDICINE (CCOM)
810 E. Third St., Suite 202
Durango, CO 81301
970-764-9850
Located in the Horse Gulch Medical Campus

LA PLATA FAMILY MEDICINE
Please be sure to ask for the Worker's Comp Physician
316 Sawyer Dr.
Durango, CO 81301
970-259-3110
Located in Bodo Park, turn right on to Sawyer Dr. (the traffic light @ Durango Mall)

If you have any questions, please contact the Workers' Compensation Coordinator, Laura Galido @ 970-247-5411 ext. 1438.

Reminder: It is the supervisor's responsibility to file the completed Accident Report Packet with the Workers' Compensation Coordinator
By Fax: 970-385-3643
By Email: email to both lgalido@durangoschools.org
nrodriquez@durangoschools.org
In Person: Human Resources Office

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Supervisor Name ___________________________ **School/Department** ______________________

The unsafe acts of persons and the unsafe conditions that cause accidents can be corrected only when they are known specifically. It is your responsibility to find them and name them and correct them.

PART I – GENERAL INFORMATION

Name of Injured ______________________________________ Position _______________________

Date of Accident _____________ Time ________ AM PM Exact Location ______________________

Time Employee Reported to Work ________ AM PM

Job or Activity at Time of Accident ____

Date and Time Supervisor was Notified of Accident ____

PART II – DESCRIPTION OF ACCIDENT (What Happened)

____
____
____

PART III – WHAT WAS THE CAUSE OF THE ACCIDENT? (Determine the cause by analyzing all the factors concerned. If an injured person, a machine or other physical condition was involved, find out how and why.)

A. Describe any UNSAFE Acts: ____
____
____

B. Describe any UNSAFE Conditions: ____
____
____

C. FUNDAMENTAL CAUSE: ____
____
____

PART IV – CORRECTIVE ACTION TAKEN (What have you done or what do you recommend to prevent a recurrence of similar accident?) ____
____
____

Has it been done? ___________ If not, give reason and timeline ____________________________________
____

Supervisor's Signature ____ Date: ________________