Denver College of Nursing

ACCIDENT REPORT

All injuries should be reported immediately

Name(s) of students(s)/employee(s) involved:	**Last FOUR digits of Social Security #:**	**Phone #:**	
Street Address:	**City:**	**State:**	**Zip Code:**
Date and time of accident:	**Location of accident:**		
Describe what happened (attach additional sheets if necessary):			
How and why did this happen (attach additional sheets if necessary):			
Describe injuries (attach additional sheets if necessary):			
Names of Witnesses (if any, if not, then N/A):			
1.	**2.**		
3.	**4.**		
Were photographs taken of the scene (please circle): Yes No	**Were police, fire or ambulance called (please circle and indicate): Yes No** **Police Fire Ambulance**		
Did injury occur on college premises (please circle): Yes No	**Hospitalized overnight as an in-patient (please circle): Yes No**		
Injury site and address:			
Name and address of treating health care professional:			
Name and address of facility where treated:			
Initial treatment (please circle): None Minor on-site Clinic/hospital Emergency room Hospital >24 hrs.			
DCN Employee this incident was reported to:			
Student/Employee Signature:		**Date Completed:**	

Please return completed form to DCN Business Office FAX: 303-295-1655 EMAIL: DSN_HR_Payroll@edaff.com

DESIGNATION OF MEDICAL PROVIDERS

Denver College of Nursing hereby designates the following medical providers to provide treatment for your work related injuries:

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Facility	*Type*	*Miles from DCN*	*Selection*
Concentra Medical Center **1730 Blake St Ste 100** **Denver, CO 80202** **P 303-296-2273**	Occupational Medicine Clinic Urgent Care Clinic	0.03	☐
Concentra Medical Center **2490 W 26th Ave Ste 200a** **Denver, CO 80211** **P 303-433-2300**	Occupational Medicine Clinic	1.10	☐
On The Mend Occupational Medicine **3900 S Wadsworth Blvd Ste 325** **Lakewood, CO 80235**	Occupational Medicine Clinic	8.49	☐
Exempla Stapleton Family & Occ. Medicine **2803 Roslyn St** **Denver, CO 80238** **P 303-403-6300**	Occupational Medicine Clinic	5.22	☐
I elect to decline or not seek further treatment			☐

Please check the box next to your choice, then sign and date on the lines below.

_____ _____

Signature of employee/student Date

The name and contact information of our authorized representative is:

Renee McMillin, Director of Business Operations

The name and address of our insurer/third party administrator is:

Travelers Insurance Company
P.O. Box 173762
Denver, CO 80217-3762
Phone: (800) 227-1538
Fax: (877) 801-9674

If you have any questions, please contact our authorized representative or insurer/third party administrator.

INSTRUCTIONS FOR USING THIS FORM AND REPORTING ACCIDENTS

All injuries should be reported immediately

- This form is for internal use to document and report accidents regardless of injury or damage. Please complete pages one and two in their entirety.

- Whenever an accident results in an injury or material property damage, please fax or email a copy of a completed Accident Report to the Director of Business Operations in the Business Office. The fax number and email address are located at the bottom of the form. The appropriate authorities will be notified.

- If you use this form to document minor mishaps or if no personal injuries or property damage resulted from the incident, please forward a copy of the report to the Director of Business Operations. The incident will be reviewed for safety and/or security concerns.

- It's advantageous to take photos of accident scenes whenever possible. Document everything that may be helpful to understanding what happened and why.

- Depending on the nature of the accident or injury, the student/employee has the option to utilize their regular medical provider or the nearest urgent/critical care center or emergency room as deemed necessary.

IF YOU ARE INJURED ON THE JOB, WRITTEN NOTICE OF YOUR INJURY MUST BE GIVEN TO YOUR EMPLOYER WITHIN FOUR WORKING DAYS AFTER THE ACCIDENT, PURSUANT TO SECTION 8-43-102(1) AND (1.5), COLORADO REVISED STATUTES.

IF THE INJURY RESULTS FROM YOUR USE OF ALCOHOL OR CONTROLLED SUBSTANCES, YOUR WORKER'S COMPENSATION DISABILITY BENEFITS MAY BE REDUCED BY ONE-HALF IN ACCORDANCE WITH SECTION 8-42-112.5, COLORADO REVISED STATUTES.