

FIRST REPORT OF INJURY

To report a claim call your service team:
Small Business Services Team at 303-361-4000 or 1-800-873-7242
Or Fax to 303-361-5000 or 1-888-329-2251

SBS

Or, go to www.pinnacol.com
PLEASE PRINT CLEARLY

Early reporting can save you money. Report all injuries immediately!

The information below allows Pinnacol Assurance's customer service representatives to quickly and accurately process your claim. Use the completed form as a guide when reporting by phone or online to save you time. Don't wait to report if you don't have all the answers.

POLICY INFORMATION

Policy Number: 4118503 Company Name: Corporate Management Group
Address or Location (if different than mailing address): 12000 N. Washington St. #350
Prepared by: Tina Title: Acc't Mgr.
E-mail: tina@cmgjob.com Fax: () -
Phone: (303) 920-1425 Date Completed: 6 / 11 / 2015

INJURED WORKER INFORMATION

Injured Worker's Social Security Number: 730 - 50 - 7380 Date of Injury: 6 / 10 / 2015
First Name: Manuel M.I. Last Name: Pasillas
Home/Mailing Address: 7785 Meade St Westminster CO 80030 Phone: (720) 829-5892
Date of Birth: 5 / 30 / 1972 Male Female Martial Status: _____
Language: English Spanish Other: _____ E-mail: _____
Occupation: _____ Date Hired: _____ / _____ / _____

Employee Status: Full-time Part-time Seasonal Volunteer Independent Contractor
Days Worked per Week: 4-5 Hours Worked per Day: 8
Pay Rate: 12.⁰⁰ Hourly Weekly Monthly Annually Other: _____

ACCIDENT / INJURY INFORMATION

Fatal Injury: Yes No If Fatal Injury: Date of Death _____ / _____ / _____
Time of Injury: _____ am pm Time Work Began: _____ Last Day Worked: _____ / _____ / _____
Full Pay on Date of Injury: Yes No
Accident Occurred on Employers Premises: Yes No If Applicable: Location Code: _____ Dept Code: _____
Accident Location: _____
City State Zip Code

Name of Employer Representative Notified: Irene Date Notified: 6 / 11 / 2015
Witnesses: _____
Name(s) and Phone Number(s)

How Did the Injury Occur: Leaving work site and tripped over matt.
Specific Activity the Employee Was Engaged In: N/A walking out to car What Equipment Was Being Used: N/A
Body Part(s) Injured: left knee Right Left Not Applicable
Type of Injury Sustained: fell on his knee
 Safety Equipment Provided Safety Equipment Used Possible Drug/Alcohol Involved Employer Questioning Liability

RETURN TO WORK INFORMATION

Has the Injured Worker Returned to Work? Yes No
Date Returned to Work: _____ / _____ / _____ Estimated Return to Work Date: _____ / _____ / _____
Is this a lost time Claim? Yes No (Claim is lost time if there is a loss of more than three scheduled work days due to the injury).

MEDICAL PROVIDER INFORMATION: Where Was Your Employee Treated?

No Medical Treatment Treated by Employer 911 Called Walk-In Clinic
 Emergency Room Hospitalized > 24 hrs/Overnight Possible Surgery

Medical Provider Name Street Address City State Zip Code Phone

Manuel called at 8:30 a.m. on 6/11/2015 and notified Irene Rival of an injury he sustained last night at work. Manuel stated that he was leaving the facility and tripped over some mats. Manuel told Irene that his leg hurt before the incident, but hurt worse after.

PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY

A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER AND THE INSURER.

1. REPORT TYPE Initial Progress Closing

2. CASE CONFORMATION

Date of Injury 6-10-15 Workers' Comp # _____
Injured Worker's Name Manuel Pasilla Insurer Claim # _____
Social Security # _____ Insurer Name Gallagher Bassett
Date of Birth 05-30-71 Insurer Phone/Fax _____
Exam Date 6-11-15 Employer Name COM 9
Acct # _____ Employer Phone/Fax 303-920-1425 303-736-7767

3. INITIAL VISIT (only)

Injured worker's description of accident/injury me cev con UN TAPETE 8 cay en mi rodilla

Are your objective findings consistent with history and/or work related mechanism of injury/illness? Yes No

4. CURRENT WORK STATUS Is Working Not Working

5. WORK RELATED MEDICAL DIAGNOSIS (ES)

6. PLAN OF CARE

a. TREATMENT PLAN

Diagnostic tools/tests evaluation
 Procedures ① knee X ray
 Therapy _____
 Medications ibuprofen
 Supplies ② knee immobilizer Defoyal Tr Panel 19
 Other referral to orthopedian for evaluation

b. WORK STATUS

Able to return to full duty on _____ to _____
 Able to return to modified duty from 6-11-15 to 6-24-15 Unable to work from _____ to _____
 Able to return to part time work on _____ for _____ hrs per day

c. LIMITATIONS/RESTRICTIONS No Restrictions Temporary Restrictions Permanent Restrictions

<input type="checkbox"/> Lifting (maximum weight in pounds) _____ lbs.	<input checked="" type="checkbox"/> Walking <u>1-2</u> hours per day
<input type="checkbox"/> Repetitive lifting _____ lbs.	<input type="checkbox"/> Standing <u>1-2</u> hours per day
<input type="checkbox"/> Carrying _____ lbs.	<input type="checkbox"/> Sitting _____ hours per day
<input type="checkbox"/> Pushing / Pulling _____ lbs.	<input checked="" type="checkbox"/> Crawling _____ hours per day
<input type="checkbox"/> Pinching / Gripping _____ lbs.	<input checked="" type="checkbox"/> Kneeling _____ hours per day
<input type="checkbox"/> Reaching over head _____	<input checked="" type="checkbox"/> Squatting _____ hours per day
<input type="checkbox"/> Reaching away from body _____	<input checked="" type="checkbox"/> Climbing _____ hours per day
<input checked="" type="checkbox"/> Repetitive Motion Restrictions <u>bending left knee</u>	

Other _____

7. FOLLOW UP CARE AND REFERRALS

a. Return Appointment Date after orthopedic eval. 6-24-15 @ 3:30pm
b. Referral for Treatment (specify) _____ Evaluation (specify) ① knee sprain
 Impairment Rating _____ Other (specify) _____

Referral Appointment to be made by Injured Worker Referring physician's office

Referred Provider's Name and Address _____

Phone Number _____

c. Discharged from care (explain) _____

Discharged for non compliance

8. MAXIMUM MEDICAL IMPROVEMENT (MMI)

Injured Worker has reached MMI Date _____
Maintenance care after MMI required? No Yes If yes, specify care _____

Injured Worker is not at MMI, but is anticipated to be at MMI in/on _____
 MMI date unknown at this time

9. PERMANENT MEDICAL IMPAIRMENT

No permanent impairment Permanent Impairment (attach required worksheets and narrative)
 Anticipate permanent impairment Needs referral to Level II physician for impairment rating (see 7 h above)

10. PHYSICIAN'S SIGNATURE

Print Name Dr. JEFFREY HAWKE, DR. FRED SCHERR Date of Report 6/11/15
Address 9195 Grant # 100 Thornton, CO 80229 License number 21964 HAWKE/ 32600 SCHERR
Telephone Number 303-292-0034

Corporate Management Group

>> Designated Provider List Notification Letter

For An Injured Worker

To complete this letter, fill in the gray fields and print on your organization's letterhead. Then hand-deliver or mail the letter to your employee when you are notified of the injury.

To: Manuel Pasillas

From: Corporate Management Group

Date: 6/11/2015

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: OCCMED CO – Thornton 1033192
Address: 550 E Thornton Pkw Ste 110
City, State & Zip: Thornton, CO 80229
Phone: 720-872-0399

2. Name: SCL Physicians - Broomfield
Address: 12169 Sheridan Blvd
City, State & Zip: Broomfield, CO 80020
Phone: 303-603-9400

3. Name: Concentra Medical Centers
Address: 3300 28th Street
City, State & Zip: Boulder, CO 80301
Phone: 303-541-9090

4. Name: HealthOne Occupational Medical
Address: 9195 Grant Street Ste 100
City, State & Zip: Thornton, CO 80229
Phone: 303-292-0034

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: Corporate Management Group 303-920-1425

Address: 12000 N Washington St #350

City, State & Zip: Thornton, CO 80241

Employer's Representative for Workers' Compensation:

Name: Tina

Phone: 303-920-1425

Hand-delivered on: 6/11/15

Mailed to injured worker on: _____


Employer's signature


Employee's signature

6/11/15
Date