PINNACOL ASSURANCE

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

SBS

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 Street, Suite 350, Thornton CO 80241

Prepared by: Caitlin Scholl (Please Print) Title: Admin. Assistant

E-mail: Caitlin@corpmgmtgroup.com Fax: (303) 736-7767

Phone: (303) 920-1425 Date Completed: 10 / 06 / 2016

INJURED WORKER INFORMATION

Injured Worker's Social Security Number: 370-62-0509 Date of Injury: 10 / 06 / 2016

First Name: Sheryl M.I. ___ Last Name: Groves

Home/Mailing Address: 3019 17th Avenue #3 Longmont CO 80503 (City / State / Zip Code) Phone: (720) 499-4753

Date of Birth: 11 / 28 / 1955 ☐ Male ☒ Female Martial Status: ___

Language: ☒ English ☐ Spanish ☐ Other: ___ E-mail: ___

Occupation: order filler · warehouse Date Hired: 6/6/2016

Employee Status: ☒ Full-time ☐ Part-time ☐ Seasonal ☐ Volunteer ☐ Independent Contractor

Days Worked per Week: 5 Hours Worked per Day: 8

Pay Rate: $11 ☒ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ Other: ___

ACCIDENT / INJURY INFORMATION

Fatal Injury: ☐ Yes ☒ No If Fatal Injury: Date of Death ___ / ___ / ___

Time of Injury: 3:00 ☐ am ☒ pm Time Work Began: 7:00 AM Last Day Worked: 10 / 06 / 2016

Full Pay on Date of Injury: ☒ Yes ☐ No

Accident Occurred on Employers Premises: ☒ Yes ☐ No If Applicable: Location Code: ___ Dept Code: ___

Accident Location: Client site: Leanin' Tree Gunbarrel (City) CO (State) 80301 (Zip Code)

Name of Employer Representative Notified: Caitlin Scholl Date Notified: 10 / 06 / 2016

Witnesses: unknown (Name(s) and Phone Number(s))

How Did the Injury Occur: Sheryl tripped on a new mat and hurt her left middle & ring fingers. (Attach Additional Information if Necessary)

Specific Activity the Employee Was Engaged In: walking What Equipment Was Being Used: none

Body Part(s) Injured: left middle + ring fingers ☐ Right ☒ Left ☐ Not Applicable

Type of Injury Sustained: jammed fingers / possible break?

☐ 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: 10 / 6 / 2016 Estimated Return to Work Date: 10 / 7 / 2016

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 US Health works - Longmont, CO

☐ Emergency Room ☐ Hospitalized > 24 hrs/Overnight ☐ Possible Surgery

Medical Provider Name	Street Address	City	State	Zip Code	Phone