Employee Initial Report of Injury

Please submit this report to management as soon as possible or within four days of injury.

Critical Data

Business Name: L&M Underground Inc.

Accident Date:

Injured Worker's Name:

Preparer Name: Preparer Title:

Preparer Email:

Preparer Phone:

Accident

Accident Location: State: Zip:

Employer Notified Name: Date Employer Notified:

How Did Injury Occur:

Specific Activity Engaged In:

Equipment Used:

Body Part(s) Injured:

Injury

Time of Injury: Time Work Began:

Returned to Work:

Witness Name: Witness Phone:

Safety Equipment Worn/Used:

If not Worn/Used, Why:

Medical

No Medical Treatment:

First-aid Treated by Employer: Was 911 Called:

Emergency Room:

Provider Name:

Provider Address:

Provider City, State, Zip:

Provider Phone:

Designated Care Providers

Check the box next to care provider used; if none used check "other" and remember these providers for future injuries.

CONCENTRATION MEDICAL CENTERS—CO-DENVER NORTH 420 E 58TH AVENUE STE 111 DENVER CO 80216 303.292.2273 ☐	SCL PHYSICIANS—GREEN MOUNTAIN 12790-A ALAMEDA PARKWAY LAKEWOOD CO 80228 303.403.6350 ☐	MIDTOWN OCCUPATIONAL HEALTH SERVICES PC 2490 W 26TH AVE STE 300-A DENVER CO 80211 303.831.9393 ☐	COLORADO OCCUPATIONAL MEDICINE PHYSICIANS 8515 PEARL ST STE 300 THORNTON CO 80229 303.853.8989 ☐	ANOTHER PROVIDER ☐