Buena Vista School District #R-31
113 North Court Street
Buena Vista, CO 81211
719-395-7002

Date

Injured Worker Name
Mailing Address
City, State, Zip

Dear *(Injured Worker):*

At **Buena Vista School District #R-31.**, we are dedicated to providing our employees with the highest level of care in the event of a work-related injury or illness. We have filed a claim with our workers compensation insurance carrier, Risk Administration Services (RAS). A representative from RAS will be contacting you with a claim number and any additional information very soon. In the meantime, you should see one of the medical providers we have selected to treat our employees when a work-related injury/illness occurs. These medical providers specialize in on the job injuries/illnesses and we want that high level of care for you. Our providers are:

1st Street Family Health **910 Rush Drive** **Salida, CO 81201** **719-539-6637**	**HRRMC Buena Vista Health Center** **28374 County Road 317** **Buena Vista, CO 81211** **719-395-9048**

In the unfortunate event of a life–or-limb-threatening emergency, you will certainly be sent to the nearest emergency medical facility. However, one of the medical providers designated above **must** provide all follow-up care.

For non-emergency injuries, please select one of the providers and see them as soon as possible. After your first appointment, please follow up with me, so we can review your medical status and work capabilities together.

If you have any questions, please contact me. Our goal is to ensure that you receive the highest level of care and recover quickly and return to work as soon as possible.

Company Contact Information	**Workers Comp. Insurance Contact Information**
Jenny Swango 113 North Court Street Buena Vista, CO 81211 719-395-7002	Risk Administration Service PO BOX 89310 Sioux Falls, SD 57109 (P) 1-800-732-1486 (F) 1-877-884-6573

DESIGNATED PROVIDER NOTIFICATION

At **Buena Vista School District #R-31**. we are dedicated to providing our employees with the highest level of care in the event of a work-related injury or illness. We are in the process of filing a claim with our workers compensation insurance carrier, Risk Administration Service. A representative from Risk Administration Service will be contacting you with a claim number and any additional information very soon. In the meantime, you should see one of the medical providers we have selected to treat our employees when a work-related injury and/or illness occurs. These medical providers specialize in on the job injuries and illnesses and we want that high level of care for you. Our providers are:

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Workers Compensation Insurance contact information
Risk Administration Service
PO BOX 89310
Sioux Falls, SD 57109
(P) 1-800-732-1486 (F) 1-877-884-6573

Delivered _____

Employer Signature _____

Employee Signature _____

TREATMENT ADVISORY

I _____, do hereby acknowledge that I have been informed of my choice of designated providers by **Buena Vista School District #R-31** as well as, the importance of medical evaluation and treatment for my work related injury and/or illness which occurred on _____. I have made the clear and conscious decision to refuse any medical treatment for any injuries and/or illnesses resulting from this event. I further acknowledge that should I need treatment at a later date for this work related injury and/or illness that I will notify my employer and seek treatment with one of the designated providers I was given.

_____ _____

Employee Date

_____ _____

Supervisor Date

Employee Accident Report

Any work related injury and/or illness must be reported to a supervisor immediately, per company policy. Additionally this form shall be completed by the injured worker and returned to their supervisor as soon as possible.

General Information:

Employee Name:_____ Position: _____

Date of Injury: _____ Time: _____

Location: _____ Witness: _____

☐ Supervisor was Notified ☐ Provided Designate Provider Notification

Briefly Describe How Injury and/or Illness Occurred: _____

_____

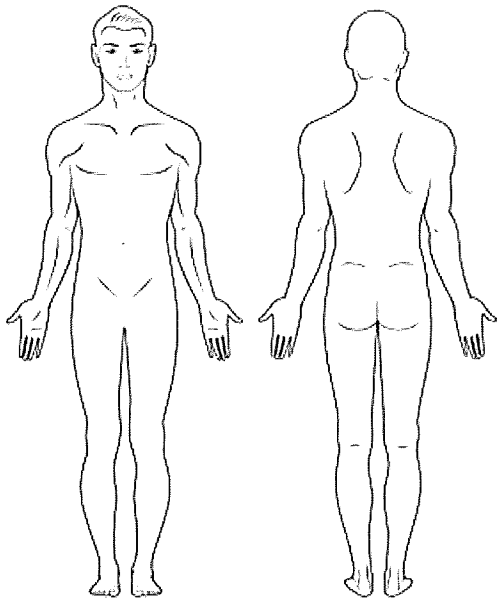
_____

Injury and/or Illness Description: _____

_____

_____

Body Part Injured:



Ways the Incident could be Avoided: _____

_____

_____

By signing below I confirm that all of the information provided here and on any attachments is complete and true to the best of my knowledge.

_____ _____

Employee Date

SUPERVISOR INCIDENT AND/OR ACCIDENT INVESTIGATION

General Information:

Injured Employee: _____ **Position:** _____

Date of Injury: _____ **Location:** _____

Time: _____ **Witnesses:** _____

Time Work Began: _____ **Last Day Worked:** _____

Incident and/or Accident Details:

Employee Description of Incident: _____

_____

_____

_____

_____

Supervisor Description of Incident: _____

_____

_____

_____

_____

Root Cause: _____

_____

_____

_____

_____

Recommendations: _____

_____

_____

_____

_____ _____ _____

Supervisor **Department** **Date**