

**COLORADO DEPARTMENT OF TRANSPORTATION
EMPLOYEE INCIDENT STATEMENT**

TYPE OF EVENT: INJURY DAMAGE TO CITIZEN VEHICLE DAMAGE PROPERTY LOSS/DAMAGE OTHER

*This form must be completed and signed by the employee reporting the injury/illness or damages. Return to your supervisor within **ONE** day of the incident.*

DATE OF INCIDENT: _____ **DATE INCIDENT WAS REPORTED:** _____

Employee Name: Street Address : City, State, Zip:	Last 4 of SSN:	Region/Section:
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Supervisor Reported to:	Supervisor's Phone #:
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Exact Time and Location of Incident:

Description of Incident (What happened?)

Cause of Incident (What caused it to happen?)

PERSONAL PROTECTIVE EQUIPMENT

Was the approved (Per PD 80.1) Personal Protective Equipment (PPE) issued? Y N

Was the approved PPE in use at the time of the incident? Y N

If **NO**, please explain: _____

Check all PPE used at the time of the incident: Hard Hat Eye Protection Hearing Protection Face Protection
 Traffic Vest Hi-Viz Apparel Gloves Boots Winter wear Coveralls Task-Specific PPE (i.e., respirator, winter tread wear, chain saw chaps, cut-resistant gloves, etc.).

WORK RELATED INJURIES/ILLNESS(S)

Pursuant to Rule 8-2 (A) of the Colorado Workers' Compensation Rules of Procedure, CDOT hereby designates the authorized treating providers (ATP's) listed on the ATP roster provided. The ATP list effective date is: _____.

I hereby acknowledge receipt of this ATP list and state that I choose to obtain medical treatment from the following provider:

ATP Provider Name: _____

I acknowledge receipt of the ATP list and I am refusing medical treatment at this time.

INCIDENT WITNESSES Y N

SIGNATURE

Employee Signature:	Date:
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