

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:

Supervisor Reported to:

Supervisor's Phone #:

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: