Please review the instructions on page 2 before completing form

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Worker's Claim for Compensation

Clear Form

Employee's name (first, middle, last)	Social Security #	Gender	Employee's phone #

Employee's street address	City	State	ZIP code

Employee's email address

Birth date	Marital status	Dependents	Date of hire	Occupation	Employment status
/ /	○ Married ○ Separated ○ Single ○ Unknown	○ Yes ○ No	/ /		○ Full-time ○ Part-time ○ Other ○ Unknown

Employer's name (company)	Employer's phone #

Employer's **mailing address**	City	State	ZIP code

Average Weekly Wage (See page 2 for instructions)

A. Average Weekly Wage from the job where the injury occurred. **Subtotal (A): $**_____

B. Average Weekly Wage from any other job held concurrently at the time of your injury. **Subtotal (B): $**_____

C. **Add subtotals of A + B** **Total Average Weekly Wage at time of injury (C): $**_____

Date of injury/disease	Time employee began work	Injury time	Last date worked	Date employer notified	Date you returned to work	Do you claim to have a permanent disability?
/ / **(See instructions)**	_____ : _____ ○ a.m. ○ p.m.	_____ : _____ ○ a.m. ○ p.m. ☐ Unknown	/ /	/ /	/ /	○ Yes ○ No ○ Unknown

Which part of the body was affected? (specify upper or lower for arms, legs, and back injuries)	Tell us the nature of the injury/illness (sprain, strain, laceration, contusion, fracture, etc.)

Describe the accident in detail (what you were doing, how the accident occurred, object that harmed you, etc.)	Name(s) and phone number(s) of witness(es), if applicable

Where did the accident occur? (street address, city, state, and county)	To whom was it reported?

Initial treatment (check one)
○ None ○ Minor on-site ○ Emergency Room
○ Clinic/hospital ○ Hospital stay over 24 hours

Do you claim to have a scar or disfigurement?
○ Yes ○ No

Name and address of treating doctor or other health care professional	Name and address of facility where treated

If claim is for an occupational disease (i.e., asbestos related, repetitive motion, hearing loss), give names of employers where the exposure occurred and dates of employment (attach additional sheet if needed).

_____ / / to / / _____
Employer Dates of employment

_____ / / to / / _____
Employer Dates of employment

Completed by _____ **Date completed** / /

For Division Use Only

SOI	POB	NOI	Coder	Adjuster code

FEIN	Policy #	Block #

Instructions for the Workers' Claim for Compensation

To ensure your claim gets processed in a timely manner, please enter all available information on page 1.

Average Weekly Wage

To determine the weekly wage, do the following:

1. Take your total gross income (before taxes) over a period of weeks and divide it by the number of weeks included.

   Total gross (before taxes) includes: any wages which were reported as income to the IRS including: regular wages; overtime; vacation; sick leave; tips; commissions; piecework; mileage; employer provided board, rent, or housing.

   Alternatively, the average weekly wage can be calculated by taking one's yearly gross income and dividing it by 52 (or the number of weeks worked), or taking one's monthly income and multiplying it by 12 and dividing it by 52.

2. On line A, enter your Average Weekly Wage for the job where the injury occurred.

3. **Repeat this process for any concurrent employment you had at the time of your injury.** The Average Weekly Wage from concurrent employment should be entered on line B.

4. Add lines A and B to determine your total Average Weekly Wage and enter that number on line C.

You may also visit dowc.cdle.state.co.us/benefits/ to use an online Average Weekly Wage calculator.

Click here to open our calculator

Date of Injury/Disease

Always include the date of injury. In the case of an occupational disease, use the date you were last exposed to the hazard.

Injury Description

Be as specific as possible when describing your injury.

Examples of good descriptions:

- "climbing a ladder while carrying roofing materials"
- "spraying chlorine from hand sprayer"
- "daily computer key-entry"
- "When ladder slipped on the wet floor, I fell 20 feet."
- "I was sprayed with chlorine when gasket broke during replacement."
- "I developed soreness in my wrist over time."

Examples of incomplete descriptions:

- "hurt"
- "pain"
- "sore"
- "fell"

Filing and Benefit Information

Upon completion, send the Worker's Claim for Compensation to The Colorado Division of Workers' Compensation, Data Entry Unit, 707 17th St., Suite 2300, Denver, CO 80202-3404 or via email to cdle_workers_compensation@state.co.us. If you need assistance filling out this form, to obtain information on benefits and dispute resolution options, or to receive a copy of the Injured Worker Guide, please contact our Customer Service Unit at 303-318-8700 or toll-free at 1-888-390-7936.

General Information

When the Division of Workers' Compensation receives your claim form, a copy will be sent to your employer's insurance carrier (carrier). The carrier has 20 days from receipt to advise, in writing, whether liability will be admitted or denied, that is, whether it accepts or denies responsibility for payment of related medical and/or lost wage benefits. If the carrier fails to admit liability within the allowed time limit, you will receive information from the Division on the options that are available to you. Always notify your employer of an injury. Failure to report an injury to the employer in writing within 10 days could result in the loss of one day's compensation for each day's failure to notify.

Notices

You are further notified that you must provide written notice of any award for social security, pension, disability, or other sources of income that might reduce your compensation benefits to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in the suspension of your benefits. "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages."

Contact Us

Division of Workers' Compensation
707 17th Street, Suite 2300
Denver, CO 80202
303-318-8700
1-888-390-7936 (Toll-Free)
cdle.colorado.gov/dwc

For more information, view our Injured Worker Guide at cdle.colorado.gov/injured-workers.

Click here to view the Injured Worker Guide