



## *Buena Vista School District*

Buena Vista School District #R-31  
113 North Court Street  
Buena Vista, CO 81211  
719-395-7004

*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:

HRRMC Salida 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.

<b>Company Contact Information</b> Brittany Tognacci 113 North Court Street Buena Vista, CO 81211 719-395-7004	<b>Workers Comp. Insurance Contact Information</b> 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:

HRRMC Salida 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.

<b>Company Contact Information</b> Brittany Tognacci 113 North Court Street Buena Vista, CO 81211 719-395-7004	Workers Comp. Insurance Contact Information Risk Administration Service PO BOX 89310 Sioux Falls, SD 57109 (P) 1-800-732-1486 (F) 1-877-884-6573
--	--

Date Signed: \_\_\_\_\_

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

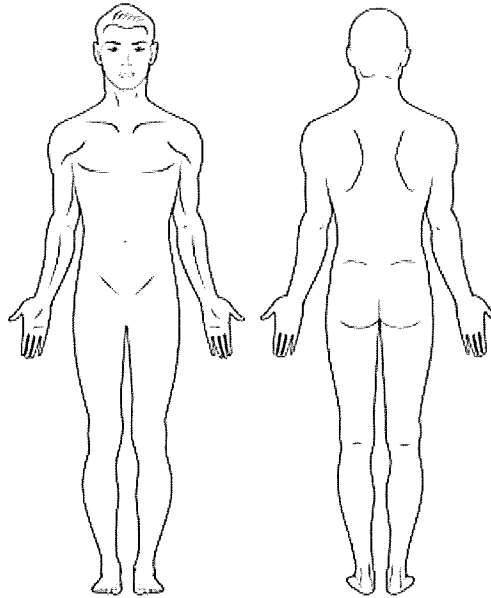
Briefly Describe How Injury and/or Illness Occurred: \_\_\_\_\_

\_\_\_\_\_

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