COLORADO DEPARTMENT OF TRANSPORTATION
EMPLOYEE INCIDENT REPORT

EMPLOYEE INFORMATION

Full Name -First Name, Middle Initial, Last Name	Personnel (PRNR) #	Region	Section	Cost Center

Employee Mailing Address Street	City	State	Zip

Home Phone	Cell Phone

Supervisor Full Name	Supervisor Cell Phone	Region Safety Officer Full Name

INCIDENT INFORMATION

Incident Date	Incident Time	Shift Start Time	Assigned work shift at time of incident
			☐ Regular ☐ Second Shift ☐ Third Shift ☐ 4/10s ☐ 24/7 Rotation ☐ JOA ☐ Flex ☐ Overtime ☐ On-Call

INCIDENT TYPE – Select all that apply

		Estimated cost to repair?
☐ Building damage ☐ Infrastructure damage	Building or infrastructure location or address:	$
☐ Equipment damage	Equipment #	$
☐ Vehicle damage	Unit #7000- Unit #5000-	$

☐ **State Fleet Commuter Vehicle damage**
Must also complete DPA Vehicle Damage Form DRM01

License Plate # Required

VIN # Required

Did the incident occur on CDOT premises? ☐ Yes ☐ No

Incident address - **if no street address, include mile markers, crossroads and towns**

Third party involved? ☐ Yes ☐ No

Police notified? ☐ Yes ☐ No ☐ N/A

Police agency _____

Citation issued? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Who received citation? ☐ CDOT Driver ☐ Other Driver

☐ **Liability - auto accident or damage to another's property**
Complete the loss description; what happened and what actions were taken, and submit any third party information received.

☐ **Work related injury or illness** MUST also complete the ATP section below!

LOSS DESCRIPTION – Briefly describe what happened. For injuries be sure to include the body part(s) injury and body side. Attach additional pages if necessary.

Personal Protective Equipment (PPE) - Select all PPE used at the time of the work related injury or occupational illness

☐ Headwear ☐ Gloves ☐ Boots ☐ Eye protection ☐ Face protection ☐ Hearing Protection ☐ Coveralls ☐ Traffic Vest ☐ Hi-Viz Apparel

Task-Specific ☐ Respirator ☐ Winter tread wear ☐ Chainsaw chaps ☐ Cut-resistant gloves

Was the incident witnessed? ☐ Yes ☐ No

Witness names and attach Witness Statements if available when submitting report.

ATP SECTION - Must be completed for every report of a work related injury/illness even if treatment is declined!

CDOT designates Authorized Treating Providers (ATPs) pursuant to Rule 8-2(A) of the Colorado Workers' Compensation Act.
I acknowledge receipt of the CDOT ATP list dated

☐ I select _____ as my ATP.

☐ I decline medical care at this time.

Employee Signature - Required	Date

Form must be printed and signed – digital signature is not available!