**EMPLOYEE'S**
**CHECK LIST**

## Processing a Reported Work Related Injury

**Employee**

**Name:_________________________________ Date:_______**

**Department:____________________________**

- ☐ **(Check One) New Injury ____ Recurrence ____**
- ☐ **CO 715 Request for Use of Accrued Leave Form**
- ☐ **WCC 1A Filing Status and Exemption Form**
- ☐ **WC 211 Third Party Liability Form**
- ☐ **Worker Status Report – Physician signature required**
- ☐ **Submitted to Human Resources on (mm/dd/yyyy)_________**
  **(Return this packet to Human Resources when completed.)**