To: All Districts
From: EDUStaff HR Department
Re: Workers Comp Procedure for all EDUStaff Employees

There are two forms an EDUStaff employee needs if they are injured. The forms and procedure are explained below.

First Report of Injury: This form is two pages and we need both pages completed. It is vital that this form is filled out completely by both the school/location and the employee and then sent to EDUStaff HR (either to humanresources@edustaff.org or fax to 877-974-6339). This form allows us to start a claim with our worker's comp carrier, if treatment was sought. If there is not any treatment sought, we still need the form as we track all injuries.

Authorization to Treat: The employee will need to take this form with them to the medical facility if they seek treatment after an injury has occurred. This form has our phone number on it as well as the basic info of our worker's comp carrier for billing/contact purposes. When this form is presented to the place of treatment they know to set it up as a work comp billing claim. We do not need this form sent to us at all, and if no treatment is being sought, the employee does not need this form either.

Where to treat: Please send our employees to the same medical facility as you send your employees. Usually that is a Concentra or occupational health type of facility. Urgent Care is also an option if you don't have occupational health locations near you. They should not go to their own personal doctor, chiro, nor the emergency room unless, of course, the injury dictates an ER visit.

Notification: We do not need to be notified immediately by phone from the employee or school location, as long as the first report of injury is filled out as completely as possible and sent to us as soon as possible. Please forward all medical bills, work notes, and any other medical paperwork to us when received.

If you have any questions on this procedure, please feel free to contact Julie Powers at 877-974-6338 ext. 140.

EDUStaff

Accident Fund Policy #6121051

Innovative Substitute Staffing Solutions for a Better Classroom

FIRST REPORT OF INJURY

Date of Report: _____/_____/_____

Date Notified Employer: _____/_____/_____

Date of Injury: _____/_____/_____ Time of Injury: _____:_____ AM/PM (circle one)

EDUStaff Employee Information:

Employee Name (Last, First, Middle): _____

SSN: _____-_____-_____ DOB: _____/_____/_____ Sex: M/F (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Phone Number: _____-_____-_____ **Hire Date:** _____/_____/_____

Job Title:_____

Injury Report Information:

Job Location: _____

DISTRICT: _____

Start Time: _____:_____ AM/PM (circle one) End Time: _____:_____ AM/PM (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Witness to Injury: _____Witness Phone Number(s): _____-_____-_____

Explain How Injury Occurred: _____

_____

_____

Nature of Injury: _____

Part of the body directly affected by the injury: _____

4120 Brockton Dr SE, Ste 200
Grand Rapids, MI 49512

P: 877.974.6338
F: 877.974.6339
www.EDUStaff.org

Last Day Worked: _____/_____/_____ Date Employee Returned: _____/_____/_____

Was the injury fatal? Yes/No (circle one) If yes, date of fatality: _____/_____/_____

Did employee seek medical treatment? Yes/No (circle one)

If yes, date of treatment: _____/_____/_____

Name of treatment facility: _____

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Restrictions: _____

_____

Expected return to work date: _____/_____/_____

District Information:

Building Supervisor: _____
(printed name and signature)

Phone Number: _____-_____-_____

Date: _____

Feedback:_____

_____

_____

_____

_____

Please return via email to Julie Powers jpowers@edustaff.org or via fax to 877-974-6339. Thanks!

AUTHORIZATION FOR TREATMENT
Workers Compensation

This form authorizes a health care provider to treat the following EDUStaff Employee:

_____

for a work related injury that occurred on _____

at _____.

Send all billing information to:

Accident Fund
PO Box 40790
Lansing, MI 48901

EDUStaff, LLC Workers Compensation Insurance

Policy Carrier: Accident Fund
Policy Number: WCV6121051