

Employee Injury

All employees are required to report all on-the-job injuries even if employee decides they do not require medical attention.

1. Employees need to report the injury to his/her immediate supervisor as soon as possible following the occurrence.
2. The supervisor is to advise the employee that he/she needs to complete an "Employee's Report of Injury" form (Attached).
3. If an employee refuses medical treatment, he/she needs to note on the top of the injury form, "For information only – no medical".
4. Should treatment be required or the employee requests treatment, the supervisor needs to contact Melissa Montgomery (ext. 2704) in the Business Office so an "Authorization for Treatment and Billing" form can be completed and provided to employee prior to treatment. If Melissa cannot be reached, contact Dawn Lagness (ext. 2705). Employees will be treated at:
 - McLaren Occupational Health Clinic (north end of Knollwood Clinic, across the street from McLaren – Lapeer Regional Hospital, 1254 N. Main Street, Lapeer, MI 48446. Hours are 8:00 AM-6:00 PM, Monday - Friday.
 - **Going to a personal physician is not approved and can result in a denied claim.**
5. It is the supervisor's responsibility to assist the employee to get medical treatment if he/she is unable or does not have someone to take them for treatment. Whenever possible, the supervisor should assume this responsibility and not have another employee take the injured worker for treatment.
6. The supervisor needs to complete the "Supervisor's Report of Accident" form (Attached).
7. Both forms, Supervisor and Employee, need to be scanned and e-mailed to Melissa Montgomery mmontgomery@nbbrncos.net for claim filing as soon as possible, but no later than 24 hours following the claim.
8. **Following treatment, employee cannot return to work until the Occupational Health paperwork provided to employee at time of treatment is submitted and reviewed by Melissa Montgomery.** Communication will follow to the employee's supervisor and employee on return to work details/approval.

EMPLOYEE'S REPORT OF INJURY

PERSONAL INFORMATION

NAME	CLAIM #	
ADDRESS	HOME PHONE	CELL PHONE
Gender: ☐ MALE ☐ FEMALE		
DATE OF BIRTH	SOCIAL SECURITY NUMBER	
OCCUPATION	EMPLOYER	DEPARTMENT
EMPLOYER ADDRESS		
NUMBER OF DAYS PER WEEK	NUMBER OF HOURS PER DAY	NORMAL DAYS OFF
LENGTH OF EMPLOYMENT	WAGES (HOURLY RATE OF PAY)	

INJURY INFORMATION

DATE OF INJURY	TIME	DATE INJURY REPORTED
Accident reported to: _____ By (name): _____		
Who witnessed accident (name & address for each person listed)? _____		
Describe fully how injury happened (continue on back if necessary): _____		
What part(s) of your body was injured? _____		
Did you stop work as a result of your accident? ☐ YES ☐ NO When: _____		
Was your pay continued during any part of your disability? ☐ YES ☐ NO		
If so, for what period? _____ Last day for which you were paid? _____		
If not working, date you expect to return to work? _____ If you did return to work, list date? _____		
From whom did you receive first medical treatment (list date)? _____		
Are you still under medical treatment? _____ How often do you receive treatment? _____		
NAME OF DOCTOR	ADDRESS	PHONE

SIGNATURE

SIGNATURE	DATE	CLAIM #
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SUPERVISOR'S REPORT OF ACCIDENT

SCHOOL DISTRICT INFORMATION

NAME OF SCHOOL DISTRICT _____

MAILING ADDRESS _____

DIVISION _____

LOCATION _____

PHONE _____

EMPLOYEE INFORMATION

EMPLOYEE'S NAME: FIRST, MIDDLE, LAST _____

HOME ADDRESS _____

HOME PHONE _____

CELL PHONE _____

☐ MALE ☐ FEMALE

DATE OF BIRTH _____

GENDER _____

SOCIAL SECURITY NUMBER _____

OCCUPATION _____

DEPARTMENT _____

ACCIDENT INFORMATION

DATE OF ACCIDENT _____

TIME OF ACCIDENT _____

☐ A.M. ☐ P.M.

REGULAR WORK? _____

Describe Injury: _____

Body part injured: _____

Witness info: _____

Fatality? ☐ YES ☐ NO

How did the accident happen? _____

Employment date: _____ How long on this job? _____

Detail all machine or equipment involved: _____

Specify activity employee was engaged in when accident occurred: _____

What safety words or safety equipment was in place? _____

What should be done to prevent repetition? _____

Has it been done? ☐ YES ☐ NO If not, give reason: _____

NAME OF PHYSICIAN _____

ADDRESS _____

NAME OF HOSPITAL _____

ADDRESS _____

SIGNATURES

SUPERVISOR'S SIGNATURE _____

DATE _____

REVIEWED BY _____

DATE _____