

## **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 Marcy Turner (ext. 2702) or Melissa Montgomery (ext. 2704) in the Business Office so an "Authorization for Treatment and Billing" form can be completed and faxed allowing employee treatment. 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-8:00 PM, Monday - Friday.
  - a. 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 Marcy Turner for claim filing as soon as possible

# EMPLOYEE'S REPORT OF INJURY

## PERSONAL INFORMATION

|                                                                       |                            |                        |
|-----------------------------------------------------------------------|----------------------------|------------------------|
| NAME                                                                  |                            | CLAIM #                |
| ADDRESS                                                               |                            | HOME PHONE             |
|                                                                       |                            | CELL PHONE             |
| Gender: <input type="checkbox"/> MALE <input type="checkbox"/> 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 # |
|-----------|------|---------|

# 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 \_\_\_\_\_