WORKERS' COMPENSATION INJURY PROCEDURES

- **ALL work-related injuries or illnesses** REQUIRE the completion of the **EMPLOYEE INJURY REPORT .** A copy of this form should be forwarded to Human Resources.

NOTE: State law requires the forms be completed and recorded within **SEVEN DAYS after the date of occurrence. Please return the forms to the Human Resource Office within the legal timeframe or we may be subject to large fines.*

IF medical attention is required:

- Employees must go to **PRO-HEALTH Urgent Care- 1268 Walton Boulevard, Rochester Hills, MI 48307 to be assessed.**

- All **EMPLOYEE INJURY REPORT** forms should be faxed or e-mailed to Human Resources immediately (248-726-3187). A delay in submitting this form may mean a delay in treatment.

- The attached **AUTHORIZATION FOR EXAMINATION OR TREATMENT** form should be completed and the employee should present it to the clinic at the time of treatment. A building administrator or secretary can sign the form. No appointment is necessary, however the hours of the facility are 8:00 am- 8:00 pm.

- The employee must also fill out the **EMPLOYER SERVICES PATIENT INFORMATION** form and present it at the time of treatment.

- **Failure to follow these steps may result in delay in treatment.**

- If the injury is life threatening, please proceed to Ascension Providence Rochester Hospital Emergency room.

- After treating with Pro-Health Urgent Care, employees may have the opportunity to treat with their own physician, however it **MUST be pre-approved** by our workers' compensation carrier before the visit or payment may be denied. Employees should contact Amy Gora directly if they would like authorization to see their own physician.

- If an employee is placed on "restrictions" by a physician and is unable to perform their own job, Human Resources will attempt to place them in a "restricted duty" position until they are able to return to their regular duty work. Please contact Amy Gora immediately if an employee is unable to work in their regular position due to a work-related injury.

- **Attendance in Absence Management can be coded by building personnel as 19-worker's comp. If you are unable to use the W/C code, please code as 01-personal illness and contact Amy Gora.**

Please contact Amy Gora at ext. 3112 if any of the procedures are unclear or questions arise regarding any workers' compensation claims.

ROCHESTER COMMUNITY SCHOOLS

EMPLOYEE INJURY REPORT

This report is to be completed by any employee of Rochester Community Schools injured on school property. Describe fully the circumstances of the injury, alleged cause and piece of equipment, furniture, etc. involved.

Name		Phone number		DEN number	
Address City, State, Zip					

INJURY/MEDICAL DATA

Date of Injury		Time		Location	

What was the employee doing just before the incident occurred. Describe activity, tools or materials. Be specific:_____

_____

How did the injury occur? Example: "When ladder slipped on wet floor, worker fell 20 feet." _____

_____

Describe the injury:_____

_____

Name the object or substance that directly attributed to the accident._____

_____

BODY PART						TYPE OF CONDITION					
	Abdomen		Forearm(s)		Ribs		Abrasion		Grinding Wound		Repetitive Motion Disorder
	Ankle(s)		Groin		Shoulder(s)		Amputation		Hearing Loss		Scratch
	Back		Hand(s)		Spine		Avulsion		Heart Attack		Silver
	Buttock(s)		Head		Stomach		Blister		Heat (cramps, stroke)		Splinter
	Calf(s)		Hip(s)		Teeth		Burn		Hernia		Sprain / Strain
	Chest		Jaw		Thigh(s)		Contusion		Infection		Slip / Fall
	Ear(s)		Knee(s)		Throat		Death		Insect bite		Other
	Elbow(s)		Leg(s)		Thumb(s)		Dermatitis		Irritation (dust)	**ACTION TAKEN**:	
	Eye(s)		Lungs		Toe		Foreign Object		Irritation (vapor)		
	Face		Mouth		Upper Arm(s)		Fracture		Laceration		
	Finger(s)		Neck		Whole Body		Frostbite		Pulmonary Condition		
	Foot		Nose		Wrist(s)		Ganglion		Puncture Wound		

Provider Name:_____ Address: _____ Phone: _____

Witness: _____ Date: _____ Phone: _____

Person Preparing Report: _____ Report Date: _____

Supervisor Signature: _____ Date: _____

Supervisor should retain a copy and send a copy of this report to Amy Gora, HR Benefit Specialist

Department of Human Resources
52585 Dequindre
Rochester, Michigan 48307
(248)726-3000

Employer Services Patient Information

Patient Information

Reason for Today's Visit

☐ Injury Care ☐ Physical Exam ☐ DOT (CDL) Certification ☐ Drug Screen ☐ Other

Social Security Number: _____ Date of Birth: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

☐ Male ☐ Female ☐ Unspecified

Email Address: _____ Pro-Health may send a detailed email: Y N

Employer Requesting Services

Company Name: Rochester Community Schools Contact Person: Amy Gora

Address: 52585 Dequindre City: Rochester State: MI Zip: 48307

Work Phone: 248-726-3112 Email Address: agora@rochester.k12.mi.us

Notice of Privacy Practices

Your name and signature below indicate that you have been made aware of Pro-Health Urgent Care's Notice of Privacy Practices on the date indicated. You understand that the Notice of Privacy Practices is posted in the center and a copy will be provided to you if you request it. If this is your first date of service with Pro-Health Urgent Care, please indicate this to the front desk receptionist and he/she will provide you a copy of the Notice of Privacy Practices. If you have any questions regarding the information in Pro-Health Urgent Care's Notice of Privacy Practices, contact 844-500-CARE of info@prohealthuc.com.

Name: (Please Print) _____ **Date Notice Received:** _____

Signature: _____ **Date:** _____

Consent

(If you are ONLY here for a Department of Transportation drug screen or breath alcohol test, skip this section. For all other services, please complete.)

The information provided is correct to the best of my knowledge. I will not hold Pro-Health Urgent Care, its health provider, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

Signature: _____ **Date:** _____

I give permission to Pro-Health Urgent Care to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnostic (e.g., including but not limited to x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements; and (c) completion of medically appropriate tests for communicable and other diseases.

Signature: _____ **Date:** _____

(Patient must present Authorization and Photo ID at the time of service)

Authorization for Examination or Treatment

Patient Name: _____ Social Security Number: _____

Employer: _____ Date of Birth: _____

Work Related

☐Injury ☐Illness ☐DOT Physical

Date of Injury: _____

DOT Physical Examination

☐Preplacement ☐Recertification

Physical Examination

☐ Preplacement ☐Baseline ☐Annual ☐Exit

Substance Abuse Testing* (check all that apply)

☐5 Panel ☐10 Panel ☐12 Panel

☐Other: _____

Special Instructions/comments

Billing (check if applicable)

☐Employee to pay charges ☐Employer to Pay Charges: Invoice _____ Pay by Phone_____

Due to the nature of these specific services, only the patient and staff are allowed in the testing/treatment area. Please notify your employee so that they can plan for children or others that might otherwise be accompanying them to the clinic.

Authorized by: _____ Title_____

Please Print

Phone: _____ Date: _____

Pro-Health Urgent Care offers Primary and urgent care services for non-work-related illness and injury. We accept most insurance plans.