INJURY ON DUTY

In the event an Employee is injured please follow protocol:

1. All injuries must be reported to Administrator.
2. In emergency situations or in doubt call 911.
3. If they are able, have employee complete the **EMPLOYEE REPORT OF INJURY** and the administrator needs to complete the **SUPERVISOR'S REPORT OF ACCIDENT** and **EMPLOYER AUTHORIZATION FOR TREATMENT** form. The **EMPLOYER AUTHORIZATION** form must accompany the Employee to the Clinic.
4. If employee is unable to complete basic injury report have supervisor complete basic information on form.
5. Advise employee to report to one of the **Occupational Health Locations** for treatment. If employee is unable call 911 and contact family member, only certified first responders are allowed to accompany an employee to clinic.
6. Be sure to send **EMPLOYEE REPORT OF INJURY** and **SUPERVISOR'S REPORT OF ACCIDENT** to Debbie Weiser in Fringe Benefits within 24 hours to file with insurance company.
7. All follow up care should be done at the District's Workers Comp. Clinic and reports sent to Fringe Benefits.

In the event you find a person incapacitated, unconscious, or seriously injured or in a life-threatening situation:

1. Call 911
2. Contact office.
3. Clear area.
4. Stay calm and try to assist person until help arrives.
5. Gather information on name of injured person and cause or type of injury.
6. Report all information known to Administrator.

EMPLOYEE COMPLETES AND SIGNS THIS FORM. Send to Fringe Benefits within 24 hours.

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 # _____

SUPERVISOR MUST COMPLETE AND SIGN THIS FORM. Send to Fringe Benefits within 24 hours.

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

☐ A.M. ☐ P.M.

DATE OF ACCIDENT | TIME OF ACCIDENT | 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

EMPLOYEE TAKES COMPLETE, SIGNED FORM TO OCCUPATIONAL HEALTH LOCATION.

St John Providence | Ascension

Ascension Crittenton

OCCUPATIONAL HEALTH PARTNERS

Employer Authorization

For Treatment/Billing

Date_____ Employee Name_____

Job Title/Duties _____

Employer _____ Phone _____

Address _____
Street City State Zip

THIS EMPLOYEE IS AUTHORIZED FOR THE FOLLOWING SERVICES. (PLEASE CHECK ALL THAT APPLY FOR THIS VISIT)

Injury Care: (Describe) _____

Date of injury: _____ Time: _____ a.m.☐ p.m.☐

Controlled Substance Test with this injury: ☐Urine Drug Screen ☐Breath Alcohol Test

Patients initially seen after hours in Emergency Department should return for follow-up care to the nearest Occupational Health Partners location. (Locations on reverse side)

Physical Exam (Bring eyeglasses and/or contact lenses and case.)

☐Post-offer/Pre-hire ☐DOT—new hire ☐MCOLES

☐Annual ☐DOT—renewal ☐Preventive Well Exam

☐Return to Work ☐Hazmat

☐Other _____

Drug and Alcohol Testing (Photo identification required.)

☐DOT Urine Drug Screen ☐Urine Drug Screen Collection Only ☐ Breath Alcohol Test (BAT)

☐Urine Drug Screen ☐Hair Testing

☐Other _____

Screening/Immunization

☐Audiogram ☐TB Test (PPD) ☐Lift Test

☐Audiogram w/Analysis ☐Hepatitis B Vaccination ☐Pulmonary Function Test (PFT)

☐EKG ☐Hepatitis B Titer ☐Vision Screen

☐Respirator Questionnaire ☐Travel Medicine (Rochester Only)

☐Respirator Fit Test (No facial hair. No tobacco, food or drink (except water) one hour prior to test)

☐Other _____

AUTHORIZED BY: _____
(Please print) Phone

AUTHORIZED SIGNATURE: _____

stjohnprovidence.org/occupationalhealth

Your Partner in Workplace Health & Wellness

34030-66980-020 (8/4/17)

Ascension Michigan Employer Solutions
Locations in Michigan to Serve Your Workplace

ALLEGAN
Ascension Borgess Allegan Hospital
551 Linn St., Suite 110 • Allegan, MI 49010
269-686-4270 • Fax: 269-686-4305
Monday, Wednesday and Friday 8:00 a.m. - 4:30 p.m.
After hours injury care available in the Walk-In Clinic
Tuesday, Thursday 8:00 a.m. - 8:00 p.m.
Monday, Wednesday 4:30 p.m. - 8:00 p.m.
Saturday 8:00 a.m. - 12:00 p.m.
Holiday hours vary

BATTLE CREEK
Health Park South
2845 Capital Ave. SW, Suite 206 • Battle Creek, MI 49015
269-962-0790 • Fax: 269-962-0828
Monday - Friday 8:00 a.m. - 4:30 p.m.

DETROIT/GROSSE POINTE WOODS
Ascension St. John Hospital
19251 Mack Ave., Suite 100 • Grosse Pointe Woods, MI 48326
313-343-3740 • Fax: 313-343-7864
Monday - Friday 7:30 a.m. - 4 p.m.

EAST CHINA
Ascension River District Hospital
4100 River Rd. • East China, MI 48054
810-329-8912 • Fax: 810-329-8913
Monday - Friday 7:30 a.m. - 4 p.m.

GRAND BLANC
Ascension Genesys Hospital
Main Entrance
1 Genesys Parkway • Suite 1620
Grand Blanc, MI 48439
810-606-5957 • Fax: 810-606-5907
Monday - Friday 7:30 a.m. - 4:00 p.m.

HOWELL
Ascension Medical Center
1225 S. Latson Rd., Suite 130 • Howell, MI 48843
517-338-2370 • Fax: 517-338-2371
Monday - Friday 7:30 a.m. - 4 p.m. After hours injury care available in Urgent Care daily until 9 p.m. and holidays 11 a.m. - 5 p.m.

KALAMAZOO
Ascension Borgess Hospital
Main Entrance
1521 Gull Road, Suite 430 • Kalamazoo, MI 49048
269-226-5177 • Fax: 269-552-0308
Monday - Friday 8:00 a.m. - 4:30 p.m.

LIVONIA
Ascension Providence Health Center
37595 Seven Mile Rd. • Livonia, MI 48152
734-432-6668 • Fax: 734-542-6108
Monday - Friday 7:30 a.m. - 4 p.m. After hours injury care available in Urgent Care daily until 10 p.m.

MACOMB TOWNSHIP
Ascension St. John Hospital Health Center
17700 23 Mile Rd.
Macomb Township, MI 48044
586-868-9120 • Fax: 586-868-9136
Monday - Friday 7:30 a.m. - 4 p.m.

MADISON HEIGHTS
Ascension Macomb-Oakland Hospital, Madison Heights
27351 Dequindre Rd.
Madison Heights, MI 48071
248-967-7715 • Fax: 248-967-7716
Monday - Friday 7:30 a.m. - 4 p.m.

NOVI
Ascension Providence Hospital, Novi Campus
Outpatient Center, Northeast Entrance
47601 Grand River Ave., Suite B230
Novi, MI 48374
248-465-4800 • Fax: 248-465-4872
Monday - Friday 7:30 a.m. - 4 p.m.

PORTAGE
Ascension Borgess at Woodbridge Hills
7901 Angling Rd.
Portage, MI 49024
269-324-8426 • Fax: 269-324-8445
Monday - Friday 8:00 a.m. - 4:30 p.m.,
After hours injury care is available in Immediate Care
Monday - Friday until 10 p.m.
Saturday 8 a.m. - 8 p.m.
Sunday 9 a.m. - 5 p.m.

ROCHESTER
Ascension Providence Rochester Hospital
South Entrance, second level parking structure
1101 W. University Dr.
Rochester, MI 48307
248-652-5203 • Fax: 248-652-5128
Monday - Friday 7:30 a.m. - 4 p.m..

SOUTHFIELD
Ascension Providence Health Pavilion
22255 Greenfield Rd., Suite 422
Southfield, MI 48075
248-849-3195 • Fax: 248-849-3390
Monday - Friday 7:30 a.m. - 4 p.m.

AFTER HOURS INJURY CARE IS AVAILABLE IN THE EMERGENCY ROOM AT ASCENSION MICHIGAN HOSPITALS