# 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

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

Concentra™

*(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: _____

Street Address: _____ Location Number: _____

Temporary Staffing Agency: _____

**Work Related**

❑ Injury ❑ Illness

Date of Injury _____

**Substance Abuse Testing★** (check all that apply)

❑ Regulated drug screen ❑ Breath alcohol

❑ Collection only ❑ Hair collect

❑ Non-regulated drug screen ❑ Rapid drug screen

❑ Other _____

**Type of Substance Abuse Testing**

❑ Preplacement ❑ Reasonable cause

❑ Post-accident ❑ Random

❑ Follow-up

Special instructions/comments:

**Physical Examination**

❑ Preplacement ❑ Baseline ❑ Annual ❑ Exit

**DOT Physical Examination**

❑ Preplacement ❑ Recertification

**Special Examination**

❑ Asbestos ❑ Respirator ❑ Audiogram

❑ Human Performance Evaluation★

❑ HAZMAT ❑ Medical Surveillance

❑ Other _____

**Billing** (check if applicable)

❑ Employee to pay charges

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

Authorized by: _____ Title: _____
Please print

Phone: _____ _____
Date

Concentra now offers urgent care services for non-work related illness and injury. We accept many insurance plans.

***(Copies of this form are available at www.concentra.com)***

Concentra®

*Improve the health of America's workforce, one patient at a time.*

# Employer Services - Injury Care
# Patient Information

Last name:_____ First name:_____ M.I.:____

Date of birth (MM/DD/YYYY):_____

Injury date:_____ Injury time: _____

Where did the injury occur? _____

_____

_____

_____

How did the injury happen? _____

_____

_____

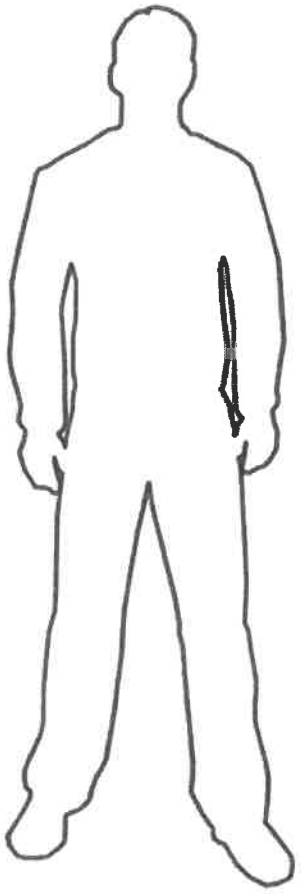
_____

What part of your body is injured? _____

_____

_____

_____



Please check which side of your body is injured. ❒ Right ❒ Left ❒ Both

Using the figure at right, please circle the areas where you are injured.

Were you seen elsewhere for this injury? ❒ Yes ❒ No

If so, where?

Name: _____

Address: _____

City: _____ ST: _____

Phone: _____

BRIGHTON AREA SCHOOLS

# Concentra Locations

## Brighton:

7960 West Grand River Rd
Brighton, Mi. 48114
Phone: 810-225-9800
Fax: 810-225-9807

## Novi:

42875 Grand River Ave
Novi, Mi. 48375
Phone: 248-478-1616
Fax: 248-478-9450

## Ann Arbor:

3131 S. State St.
Ann Arbor, Mi. 48108
Phone: 734-213-6285
Fax: 734-213-6482

## Livonia:

34095 Plymouth Rd
Livonia, Mi. 48150
Phone: 734-513-2000
Fax: 734-513-7263