Flushing Community Schools

522 N. McKinley Road, Flushing, MI 48433
Phone: (810) 591-1180 ~ Fax: (810) 591-0656

Andrew Schmidt, Deputy Superintendent

March 8, 2023

Dear Employee,

We are committed to providing a safe working environment for all employees. Accident and injury prevention are our main goal, but if you are injured while on the job, we want to make sure you receive the care needed to get well again.

We have recently partnered with **AMD URGENT CARE (in addition to Convenient Urgent Care)** to ensure quality medical treatment and a smooth process for workers' compensation claims. Medical treatment outside of AMD Urgent Care or Convenient Urgent Care may NOT be eligible for compensation under the state's workers' compensation law.

All employees should be familiar with the steps necessary to seek treatment for injuries occurring at work. Our procedure is listed below.

WHEN AN EMPLOYEE IS INJURED

- If this is a life-threatening injury, please call 911.
- Employee reports accident to immediate supervisor.
- If it is not a life-threatening emergency, employee immediately completes an Employee's Report of Accident form and sees an onsite nurse, if available.
- The supervisor immediately completes and submits the Supervisor's Report of Accident and sends both reports to Personnel Specialist Christina Brokaw christina.brokaw@flushingschools.org to report the claim to our work comp carrier, CCMSI.
- The supervisor will provide the employee with a signed Initial Authorization to Treat form.
  - *Employees MUST take this form to one of the facilities located on the Initial Authorization to Treat Form for initial treatment.*
- After the clinic visit, employees must provide a hard copy of the clinic's activity status and discharge report to the Personnel Office.
- AMD Urgent Care and Convenient Urgent Care will work with our workers' compensation claim representative to ensure quality of care and approve future visits and prescribed treatments, including physical therapy, diagnostic tests, and specialist referrals.
- The Deputy Superintendent will work with employee's supervisor on restricted work options.

Copies of the above-mentioned forms are located in your building principal's office and our District's website under Staff Resources / Employee Forms.

If you have any questions or concerns about these procedures or how workplace injuries are managed, please contact Personnel Specialist Christina Brokaw at 810-591-1186 or via email at: Christina.Brokaw@flushingschools.org

Once again, we are committed to the safety of all employees. If you have a safety concern or any ideas for safety improvements, please contact your immediate supervisor.

Sincerely,

Andrew N. Schmidt
Deputy Superintendent

"Preparing learners today for opportunities tomorrow."

Employee Accident / Injury Report Form

FLUSHING COMMUNITY SCHOOLS

Accident reports are to be completed for every accident occurring on school property where the injured person requires immediate or subsequent medical attention. It is the responsibility of the building administrator or immediate supervisor to forward this report to the ***Personnel Office.***

All fields must be completed by employee. Please print clearly.

Name: _____ **Job Title:** _____ **Building:** _____

Date of Accident: ___/___/___ **Time of Accident:** _____ am pm **Date Accident Reported:** ___/___/___ **Time:** _____ am pm

Time employee began work: _____ am pm **When did employee return to work?:** ___/___/___ **Time:** _____ am pm

Birth Date: ___/___/___ **Marital Status:** Single Married Divorced Widowed **Gender:** ☐ M ☐ F

Home Address: _____ **City:** _____ **Zip:** _____

Home Phone: (_____) _____ **Alternate Phone:** (_____) _____

NATURE OF INJURY / INCIDENT:

☐ Allergic Reaction	☐ Cut	☐ Fracture	☐ Psychological / Psychiatric Incident	☐ Other: _____
☐ Asthma	☐ Electrical Shock	☐ Head Injury	☐ Seizure	
☐ Back/Spinal Injury	☐ Eye/Facial Injury	☐ Loss of Consciousness	☐ Sprain	
☐ Burn	☐ Fall	☐ Loss of Tooth		

☐ Illness, severe enough to cause immediate transfer for medical care: _____

PART OF BODY INJURED:

☐ Ankle L/R	☐ Ear L/R	☐ Finger L/R	☐ Head	☐ Mouth	☐ Shin L/R	☐ Tailbone	☐ Toe L/R
☐ Arm L/R	☐ Eye L/R	☐ Foot L/R	☐ Knee L/R	☐ Neck	☐ Shoulder L/R	☐ Teeth	☐ Wrist L/R
☐ Back	☐ Face	☐ Hand L/R	☐ Leg L/R	☐ Nose	☐ Stomach	☐ Throat	☐ Other: _____

LOCATION ACCIDENT TOOK PLACE: Building: _____

☐ Auditorium	☐ Gymnasium	☐ Media Center	☐ Shop: _____
☐ Cafeteria	☐ Hallway	☐ Parking Lot	☐ Sidewalk
☐ Classroom	☐ Laboratory	☐ Rest Room	☐ Other: _____

DESCRIPTION OF ACCIDENT: How did the accident happen? What was the employee doing? List specifically unsafe acts and unsafe conditions existing.

_____

_____

_____

WITNESS NAME: _____ **PHONE:** _____

INITIAL MEDICAL TREATMENT: ☐ None Required ☐ Refused ☐ First Aid Only ☐ Physician/Facility Visit ☐ Emergency Room

☐ 911 Called **(Notify Central Office – do not leave voicemail)**

☐ First Aid: _____ Administered By: _____

EMERGENCY CONTACT NOTIFIED:

Emergency Contact Name: _____ Date: ___/___/___ Time: _____am/pm

FOLLOW UP:

Hospital: _____ Address: _____ City: _____ Zip: _____

Ambulance Company: _____ Treating Doctor: _____

Resulting Injury / Diagnosis: _____

_____	___/___/___	_____	___/___/___
Employee Signature	**Date**	**Supervisor's Signature**	**Date**

PERSONNEL OFFICE USE ONLY:

Date Claim Reported: ___/___/___ **Claim #:** _____ **Action:** _____

SUPERVISOR'S REPORT OF ACCIDENT

SCHOOL DISTRICT INFORMATION

Flushing Community Schools
NAME OF SCHOOL DISTRICT

522 N. McKinley Rd., Flushing, MI 48433
MAILING ADDRESS

Work Comp | Building: _____
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

Flushing Community Schools

522 N. McKinley Road, Flushing, MI 48433
Phone: 810-591-1186

INITIAL AUTHORIZATION TO TREAT FORM

All additional treatments/services beyond first visit need approval from CCMSI.

Employer: please complete this form and send with employee for work-related injury or Hepatitis B Vaccine Series.

Employee Information

Name:	Date:
Date of birth:	Social Security number:
Location where accident/injury occurred:	
Date of injury:	Injured body part(s):
Brief description of injury/accident:	

Employer Information

Employer:	
Phone:	Fax:
Address:	
Authorized signature:	Printed name & title:

The employer accepts responsibility and authorizes initial treatment, including diagnostic testing, for the employee listed above under a self-insured workers' compensation program managed by a third-party administrator. The employee is to be treated for injuries under the provisions of the Michigan Worker's Disability Compensation Act.

Billing Information

Workers' compensation insurance/third-party administrator:
Cannon Cochran Management Services Inc. (CCMSI)

Billing address:
2364 Woodlake Drive, Ste. 100, Okemos, MI 48864

Phone: 517.347.2331	Fax: 217.477.5970	Claim number:

All additional treatments/services beyond initial visit need approval from CCMSI. *The employer, via CCMSI, will pay related and reasonable charges provided that these charges are accompanied by medical records submitted directly to CCMSI. The patient is financially responsible for all other services unless otherwise authorized.*

Authorized Medical Clinics and After-Hours Care

Clinic	Address	City	Phone	Hours	Days
AMD Urgent Care	*7070 Miller Rd.*	*Swartz Creek, 48473*	*810-564-7995, opt 3*	*9:00am-10:00pm 10:00am-10:00pm*	*Mon-Fri Sat-Sun*
AMD Urgent Care	*11307 N. Linden Rd.*	*Clio, 48420*	*810-564-7995, opt 2*	*10:00am-10:00pm*	*7 days / week*
AMD Urgent Care	*1451 N. Leroy St.*	*Fenton, 48430*	*810-564-7995, opt 6*	*10:00am-10:00pm*	*7 days / week*
AMD Urgent Care	*1477 S. State Rd.*	*Davison, 48423*	*810-564-7995, opt 5*	*10:00am-10:00pm*	*7 days / week*
Convenient Urgent Care	*6020 Pierson Rd.*	*Flushing, 48433*	*810-720-1200*	*8:30am-7:00pm 8:30am-5:00pm*	*Mon-Fri Sat-sun*

Please go to page 2

District name: **Flushing Community Schools**		
Employee name:		
Medical Diagnosis *(to be completed by medical provider)*		
Injured body part(s):		
Medical diagnosis:		
Is condition work related? ☐ No ☐ Yes	Is employee able to return to work full duty? ☐ No ☐ Yes	Is employee fully disabled? ☐ No ☐ Yes
If unable to perform full duties, please specify restrictions:		
If employee is fully disabled, what is the estimated time away from work?		
Physician name (please print):		Phone:
Address:		
Physician's signature:		Date:
Date & time of next office visit:		

********Please note ********

All additional treatments/services beyond initial visit need approval from CCMSI. The patient is financially responsible for all other services unless otherwise authorized.

When completed, please fax both pages to:

Flushing Community Schools
Attn: Christina Brokaw, Personnel Specialist
Fax: 810-591-0656
For questions, please call 810-591-1186