

Grand Blanc Community Schools Employee Report of Injury

ACCIDENT REPORTING: All work-related injuries must be reported immediately.

It is the supervisor's responsibility to report the injury to the Benefits Office at 810-591-6013 immediately. If an injury occurs and you cannot reach Anita Gould, please contact Angela Arrand at 810-591-6003. **The Benefits Office will authorize medical treatment.** Within two days of knowledge of the injury, all necessary forms must be submitted to the Benefits Office.

All non-emergency examinations or procedures should be handled by one of the clinics shown below. Grand Blanc Community Schools will not pay medical bills for an employee's personal physician for a worker's compensation injury unless prior approval is obtained.

- **Henry Ford Occupational Health - Genesys Hospital**
Genesys Hospital – main entrance (not the emergency room entrance)
One Genesys Parkway, Suite 1620, Grand Blanc MI 48439
(810) 606-5957
Monday - Friday 7:30 AM to 4:00 PM

- **Hurley Occupational Health Services**
Hurley Urgent Care – Burton
2065 S. Center Road, Burton MI 48519
(810) 262-2360
Monday - Friday 10:00 AM to 10:00 PM
Saturday - Sunday 10:00 AM to 6:00 PM

If the injury occurs when the clinic is closed, employees are directed to the Henry Ford Genesys Hospital emergency room for treatment. Inform the admissions staff it is a work-related injury. All follow up treatments will occur at the clinic.

EMERGENCY: If it is an immediately life-threatening emergency, seek medical attention first and then report as soon as possible. If the nature of the injury is serious enough to warrant an ambulance and/or emergency hospital care, the requirement to visit the above medical clinic may be waived. In these cases, employees are directed to the Henry Ford Genesys Hospital emergency room for treatment.

INJURY AND ILLNESS INCIDENT REPORTS: These forms are used by Grand Blanc Community Schools and OSHA to develop a picture of the extent and severity of work-related incidents. Upon notification that an incident has occurred, the Benefits Office will request the Employee's Report of Injury & Supervisor's Report of Accident. The supervisor will submit both forms within two days of knowledge of the injury. It is important to obtain reports from all employee accidents even those reports of injury not requiring medical attention and/or not resulting in lost time from work.

CONTRACT EMPLOYEES: For contract employee injuries, the individual needs to contact the supervisor of the company where employed to report the injury.

EMPLOYEE'S REPORT OF INJURY

PERSONAL INFORMATION

NAME	CLAIM #	
ADDRESS/CITY	HOME PHONE	CELL PHONE
Gender: <input type="radio"/> MALE <input type="radio"/> FEMALE		
DATE OF BIRTH	SOCIAL SECURITY NUMBER	
OCCUPATION	EMPLOYER	LOCATION
EMPLOYER ADDRESS/CITY		
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
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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? _____

Do you plan to seek medical treatment? YES NO If yes, where? _____

Are you still under medical treatment? _____ How often do you receive treatment? _____

NAME OF DOCTOR	ADDRESS/CITY	PHONE
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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 _____

A.M. P.M.

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 _____