

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.

- **Ascension Michigan At-Work**

Ascension 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 Ascension 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 Ascension 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: ☐ MALE ☐ 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 #
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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