PROCEDURES FOR REPORTING EMPLOYEE INJURY

To simplify the process of a Workers' Compensation claim, it is vital to properly document a potential claim from its onset. In order to accomplish this, you must follow these procedures:

1. All supervising personnel will have appropriate forms on which to record accident/employee data, i.e., Employee's Report of Injury and Supervisor's Report of Accident.

2. Every accident is to be ***immediately reported*** to the employee's supervisor. The injured worker should fill out the Employee's Report of Injury form unless the worker requires immediate medical attention. In that case, the supervisor can fill out the form at a later time. In the event emergency medical treatment is needed, the employee should be treated at either Mecosta County General Hospital in Big Rapids or Central Community Hospital in Mt. Pleasant. For all injuries that are not emergencies, employees are to seek medical treatment at **Central Occupational Medicine Program, University Park, 2600 Three Leaves Dr., Mt. Pleasant. Phone 989-773-2339**.

3. The supervisor is to report all accidents to the Business Office immediately. Authorization for medical treatment will come from the Business Office. The employer will determine where the employee is to be treated.

4. A list of all witnesses will be written up.

5. Any defective equipment should be tagged and removed from service or use.

6. The Business Office will investigate all accidents.

7. After the initial treatment, the injured employee will report back to the Business Office with a disability status slip. If the injured worker is released to modified duty, all efforts will be made to accommodate the medical restrictions.

Updated 2.24.05

SUPERVISOR'S REPORT OF ACCIDENT

COMPANY ______________________ MAILING ADDRESS ______________________

DIVISION ______________________ LOCATION ______________________

EMPLOYEE'S NAME — FIRST / MIDDLE / LAST	SOC. SEC. NO	AGE	SEX
HOME ADDRESS	OCCUPATION		

DATE OF ACCIDENT	TIME OF ACCIDENT A.M. / P.M.	DEPARTMENT REGULAR WORK?

DESCRIBE INJURY

FATALITY ☐ NO ☐ YES

HOW DID ACCIDENT HAPPEN?

EMPLOY-MENT DATE | HOW LONG ON THIS JOB?

MACHINE OR EQUIPMENT INVOLVED?

UNSAFE ACTS PERFORMED

UNSAFE CONDITIONS PRESENT

WHAT SHOULD BE DONE TO PREVENT REPETITION?

HAS IT BEEN DONE?	IF NOT, GIVE REASON

NAME OF PHYSICIAN ADDRESS

NAME OF HOSPITAL ADDRESS

SUPERVISOR'S SIGNATURE	DATE	REVIEWED BY	DATE

AL 252 (C)

EMPLOYEE'S REPORT OF INJURY

NAME ______________________________ CLAIM # __________

ADDRESS ______________________________

OCCUPATION __________ DATE OF BIRTH __________ SOCIAL SECURITY NO. __________

SEX ______ MARRIED OR SINGLE __________ EMPLOYED BY __________

EMPLOYER'S ADDRESS ______________________________

DEPARTMENT ________ BADGE NO. ________ NUMBER DAYS/PER WEEK YOU WORK ________ NORMAL DAYS OFF ________

LENGTH OF EMPLOYMENT ________ WAGES (HOURLY RATE OF PAY) ________ NUMBER HOURS WORKED/DAY ________

IF YOU HAVE DEPENDENT CHILDREN UNDER 21 YEARS OF AGE LIVING WITH YOU COMPLETE THE FOLLOWING:

Name of Dependent Child	Age	Name of Dependent Child	Age

WHICH OF ABOVE DEPENDENT CHILDREN WERE NOT AT LEAST 50% SUPPORTED BY YOU?

____

DATE OF INJURY __________ TIME __________ DATE INJURY REPORTED __________

ACCIDENT REPORTED TO __________ BY (NAME) __________

WHO WITNESSED ACCIDENT? (NAME & ADDRESS) __________

DESCRIBE FULLY HOW INJURY HAPPENED __________

____

____

____

______________________________ (Continue on back if necessary)

WHAT PART(S) OF YOUR BODY WERE INJURED __________

DID YOU STOP WORK AS A RESULT OF YOUR ACCIDENT __________ WHEN __________

WAS YOUR PAY CONTINUED DURING ANY PART OF YOUR DISABILITY __________

IF SO FOR WHAT PERIOD __________ LAST DAY FOR WHICH YOU WERE PAID __________

IF NOT WORKING WHEN DO YOU EXPECT TO RETURN TO WORK __________ IF YOU DID RETURN WHAT WAS THE DATE __________

FROM WHOM DID YOU RECEIVE FIRST MEDICAL TREATMENT __________ DATE OF TREATMENT __________

ARE YOU STILL UNDER MEDICAL TREATMENT __________ HOW OFTEN DO YOU RECEIVE TREATMENT __________

NAME OF DOCTOR TREATING YOU __________

ADDRESS OF DOCTOR __________ PHONE NO. __________

CHIPPEWA HILLS
School District
Commitment to Quality

SIGNATURE ______________________________ DATE __________

CLAIM NUMBER ______________________________