

INCIDENT REPORT FORMS INSTRUCTIONS

WHEN AN EMPLOYEE IS INVOLVED IN AN INCIDENT AND/OR IS INJURED,

It is the EMPLOYEE's responsibility to:

- Notify his/her supervisor immediately; and
- Complete and sign the Employee Incident Report immediately.

(if medical attention is required, use the Combination Form for the following)

- Sign a completed Release of Medical Records for Health Care Benefits;
- Take the Authorization for Medical Treatment & Payment on his/her appointment with the designated provider;
- Return the completed Treatment and Work Status Form completed by the provider to the Plan Administrator immediately after seeing the physician.

The SUPERVISOR must:

- Assist the employee in all of his/her responsibilities, if necessary;
- Immediately notify the Plan Administrator of the Occupational Injury Benefit Plan of the incident and/or injury.
 - Have witness(s), if any, fill out Witness Incident Report(s);
 - Submit the original Incident Reports to the Plan Administrator of the Occupational Injury Benefit Plan.

The PLAN ADMINISTRATOR will:

- Complete and sign an Authorization for Medical Treatment & Payment (on the Combination Form if the employee(s) requires medical attention);
- Make certain all documents have been completed by the employee and supervisor;
- Gather all relevant information, observe the exact location of the incident, and complete and sign the Insurance Carrier's Accident Report.

IN AN EMERGENCY, PRIORITIZE MEDICAL ATTENTION; FOLLOW-UP WITH THE PAPERWORK IMMEDIATELY THEREAFTER.

EMPLOYEE INCIDENT REPORT

(Please print clearly and give this report to your supervisor before the end of your shift)

COMPANY _____

Full name of employee involved/injured: _____

Home Address: _____

SS#: _____ DOB: _____ Sex: _____

Date and time of incident: ___/___/___ - _____ a.m./p.m.

Exact location of incident: _____

Department: _____ Supervisor: _____

Job Title: _____

Incident Facts: Describe exactly what happened (i.e., how incident occurred and if an injury resulted, state part of body injured and nature of injury.)

Statement of involved/injured employee:

Was a specific tool, machine or piece of equipment involved? Yes [] No [] If yes, describe:

Were there witnesses? Yes [] No [] If yes, list below:

Employees:

Other:

Name: _____

Name: _____

Department: _____

Phone #: _____

Name: _____

Name: _____

Department: _____

Phone #: _____

Date

Signature of Employee

WITNESS INCIDENT REPORT

COMPANY _____

Name of Witness: _____ Phone No.: _____

Address: _____

Are you a(n) employee [] visitor [] other []?

Department: _____ Job Title: _____

Location of Incident: _____

Date of Incident: _____ Time Occurred: _____ a.m. _____ p.m.

Name(s) of Employees involved in Incident: _____

Incident Facts: Describe exactly what happened (i.e., how incident occurred and if an injury resulted, state part of body injured and nature of injury.)

Statement of witness:

Did the employee involved say anything following the incident? Yes [] No [] If yes, please state remarks as accurately as possible.

Was a specific tool, machine or piece of equipment involved? Yes [] No [] If yes, describe:

Date

Signature of Witness

AUTHORIZATION FOR MEDICAL TREATMENT & PAYMENT

_____ hereby authorizes _____
(Employer) (Medical Provider)
to provide treatment for our employee, _____. Your statement for services should be sent
directly to us for payment Authorization – OneTime / Subsequent (circle one)

COMPANY: _____
ADDRESS: _____
CONTACT: _____ PHONE# : _____

If you determine hospitalization, surgery, referrals or any diagnostic test outside your office are necessary, please notify our Plan Administrator. Your cooperation in communication with our Plan Administrator when they contact your office is appreciated.

Signature _____ Date _____
(Employer Representative)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize any emergency room, hospital, physician or other allied health practitioner to release all medical information concerning my work-related injury to my employer and/or their Plan Administrator. Thank you for your cooperation.

Signature _____ Date _____
(Employee)

TREATMENT AND WORK STATUS

This is to advise you that _____ has a modified work program. We are fully committed to the health and safety of all our employees. We assure you we will abide by any and all restrictions you feel are medically necessary. Please complete the work status information below and give to the employee to return to us.

- Employee is _____
_____ Medically able to return to regular work
_____ Discharged from care
_____ Medically unable to return to any type of work at this time
_____ Medically able to return to some form of modified work

Restrictions necessary for modified work

Diagnosis _____

NEXT APPOINTMENT SCHEDULED ON _____ @ _____ AM/PM

Signature _____ Date _____
(Physician)