EMPLOYEE Incident Report

Employer Name		Location Code:	Position/Title: Employee ID:		Location of Incident:	
Employee Name (First, Middle, Last):		Date of Injury:	Time of Injury: am / pm	Date/Time Notified of Injury:	Gender: ☐M ☐F	Marital Status: ☐S ☐M ☐D # Dependents:
Employee Street Address:		Hire Date:	SSN:	Date of Birth:	Was 911 Called?: ☐Y ☐N	
Employee City, State, Zip	Home Phone:	Facility Phone:	Hourly Wage: $	Avg. Hours Worked per Week:	Status: ☐Active ☐Temp ☐Terminated / Term Date:	
Callers Name: / Callers Title:	Has/Will Emply miss work beyond the date of injury? ☐Y ☐N	Last Date Worked:	Return To Work Date:	Salary Continued? ☐Y ☐N	Did Employee Receive Full Benefits?	☐Full Time ☐Part Time

Briefly describe incident/exposure:

INCIDENT / EXPOSURE / MEDICAL DETAILS

Cause of Injury:
☐resident movement ☐material handling ☐struck by/against ☐splash/biologic agent
☐slips/trips/falls ☐repetitive motion ☐caught between ☐needlestick
☐laceration ☐burn/scald ☐struck by resident ☐other

Type of injury:
☐sprain/strain ☐burn ☐splash/biologic material
☐cut/laceration/puncture ☐fracture ☐chemical/poisoning
☐bruise/crushing ☐shock/heat stress ☐other

Doctor / Hospital Name:
Address:
City/State/Zip:
Phone:

Body part affected:
☐hand/wrist (R or L) ☐head ☐shoulder (R or L)
☐arm/elbow (R or L) ☐back ☐foot/ankle (R or L)
☐leg (R or L) ☐other

Device in use at time of injury:
☐gait belt ☐PPE ☐wheelchair
☐mechanical lift ☐brakes ☐spring load bottoms
☐slide sheet/draw sheet ☐syringe safety device ☐blind spot mirrors
☐dolly ☐Lockout/tagout ☐other:

If a specific resident was involved in this incident; record resident's mobility & transferring instructions from the MSD here:

Were safety rules violated? ☐Yes ☐No

Are there other violations by this employee? ☐Yes ☐No **If yes, date and type of disciplinary action:**

Is employee currently under disciplinary action? ☐Yes ☐No

Did this incident involve a third party (non-employee)? ☐Yes ☐No

Provide name of company, of product, equipment or tool or other person

How could this incident have been prevented?

What corrective actions have you taken to prevent future incidents of this kind?

Witnesses (Name, Title)		
1.	**2.**	**3.**

Ensure that all blanks are completed in detail; attach witness statements and all other information concerning the claim.

Print Supervisor's Name _____ Supervisor's Signature _____ Date _____

Print Employee's Name _____ Employee's Signature _____ Date _____

This form is for internal use only.

Employee Incident Report
EMPLOYEE STATEMENT

Please complete this form in your own handwriting and return to your employer immediately

Location:_____ **Address:** _____

Injured Employee Name: _____ **Date of Injury:** _____
Time of Injury: _____ **AM/PM**

ACCIDENT INFORMATION:

What were you doing at the time of the incident?

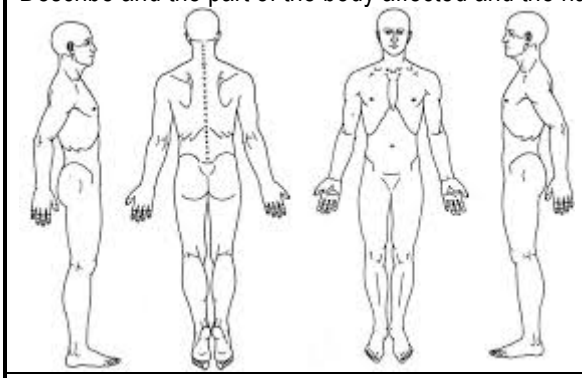
Who was around you at the time?

Describe exactly how the incident happened:

Was a resident involved?

Describe where the incident happened:

Describe and the part of the body affected and the nature of the injury (initial affected body parts on the below illustration):



I decline treatment at this time. ☐ Initial box)

Describe what you could have done differently to avoid the incident:

By my signature, I certify that the above information is correct and that I have completed this form truthfully without any coercion from my employer.

Dated_____ Signature: _____

EMPLOYEE MEDICAL RECORDS RELEASE FORM

I, _____ SSN: _____

Hereby authorize any health care provider, hospital, clinic, dispensaries, druggist, employers, and/or any other Payer or health care facility where I have been evaluated, treated, and/or in whose possession my health care records are located to engage in verbal and written contact with and to furnish (Employer Name)_____ and Normandy Insurance and their authorized representatives any and all information which may be requested regarding my medical condition, treatment rendered and/or other diagnostic records and tests- including Independent Medical Exams (IMEs). Included, but not limited to current exemptions for information relating to Florida Workers' Compensation under the Health Insurance Portability and Accountability Act (HIPAA), this consent specifically covers any and all records and documents protected by any current statute or regulation.

A photocopy or facsimile of this authorization shall have the same force and effect as the original.

Employee Signature: _____ Date: _____

Witness: _____ Date: _____

DRUG FREE WORKPLACE AND DRUG TESTING POLICY

I have received a copy of the Company's Drug Free Workplace and Drug Testing Policy. I understand that the company prohibits being under the influence of, or any activities associated with, illicit drugs, alcohol and abuse of controlled substances while at work.

I understand that the Company will be employing drug and alcohol testing of applicants and employees in its attempt to enforce it Drug Free Workplace policy and ensure the safety of its employees, residents and guest.

I am aware that employees may be required to submit to testing for the presence of illicit and prohibited substances post-incident/injury/accident or when the company has "reasonable suspicion" to believe an employee may have violated the Drug Free Workplace and Drug Testing Policy. Please refer to the policy for further information on this topic.

I am aware that any violation of this policy may result in disciplinary action up to and including discharge, for cause, and that a positive drug test related to a work injury may affect Workers' Compensation benefits.

I am aware that the Company considers refusal to submit to testing when requested as an admission of guild=t and that such a refusal may result in disciplinary action up to and including discharge, for cause.

I understand that I am expected to read this policy and, if unsure of any part therein, I will bring my concerns forward to an appropriate member of management.

_____ _____ _____

Signature of Employee Printed Name Date

WITNESS STATEMENT

Please complete this form in your own handwriting and return to your employer immediately

Location:_____ **Address:** _____

Injured Employee Name: _____ **Date of Injury:** _____

WITNESS INFORMATION:
Witness Name:
Address, City, State, Zip:
Telephone No.:

ACCIDENT INFORMATION:
What were you doing when you witnessed the accident?
Describe how the accident happened:
Describe where the accident happened:
Describe the part of the body injured:

By my signature, I certify that the above information is correct and that I have completed this form truthfully without any coercion from my employer.

Dated_____ Signature: _____

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EMPLOYEES RESPONSIBILITY UNDER WORKERS' COMPENSATION

Please read the following responsibilities carefully. Failure to comply these responsibilities may result in disciplinary action and may affect workers' compensation benefits.

If you have any questions or concerns about your responsibilities following an on-the-job injury, please contact the Workers Compensation Administrator or your Supervisor.

1. Our goal is to have you return to gainful employment as quickly as possible.

2. Unless otherwise directed, you are required to receive medical treatment from designated physicians.

3. **IMMEDIATELY AFTER** receiving medical treatment:

    a. **CALL YOUR DEPARTMENT SUPERVISOR/RETURN TO WORK COORDINATOR** with the following instructions:

        ☑ Your return-to-work status
        ☑ The treating doctor's name, address, and phone number

    b. **REPORT BACK TO WORK IN PERSON** as soon as you are physicallyable to report and provide your copy of the claim form and the written release from your doctor.

Bring a copy of the written release from the doctor or your DEPARTMENT SUPERVISOR immediately following your visit.

4. **KEEP YOUR EMPLOYER INFORMED AT ALL TIMES ABOUT YOUR WORK STATUS**. Following each medical visit, you must provide a release written by your doctor, containing information about your medical condition and your return-to-work status, including physical limitations, if any. You must provide an updated release no later than 24 hours following EACH medica l visit.

5. **COOPERATE WITH YOUR EMPLOYER AND MEDICAL PROVIDERS** in exploring modified (light) duty assignments, if applicable. Whenever possible, EMPLOYEES will work in a modified position within their physical limitations identified by the treating doctor so they may continue to earn an income as they recover from their injury.

    a. You must follow all treatment orders and not exceed restrictions imposed by the doctor while on modified duty **or at home**. Failure to follow the doctor's restrictions may result in disciplinary action up to and including termination.

6. **ARRANGE** follow-up medical visits outside of working hours or pre-arrange time away with your DEPARTMENT HEAD/SUPERVISOR.

7. **ATTEND ALL SCHEDULED MEDICAL APPOINTMENTS**, unless an emergency arises that forces you to reschedule your appointment. Please notify you supervisor when an emergency requires you to reschedule an appointment.

8. **KEEP YOUR HUMAN RESOURCES RESPRESENTATIVE INFORMED** of your current address and phone number, and the name, address and phone number of your doctor.

9. **IF YOU RECEIVE A MEDICAL BILL FOR YOUR WORK-RELATED INJURY**, take it to your employer or send it directly to your workers' comp claims adjuster.

10. **IF YOU FEEL THAT YOU ARE NOT RECEIVING ALL THE WORKERS' COMP BENEFITS ENTITLED TO YOU**, please contact your supervisor, or Administrator for assistance.

Thank you in advance for your cooperation. It is our goal to ensure the prompt delivery of any Workers' Compensation benefits entitled to you.

Print Team Member's Name	Team Member's Signature	Date

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TREATMENT REQUEST FORM

Date:	**Facility Name:**
Facility Address:	**Contact Person and Phone No.**
Employee Name:	**Job Title:**
Social Security No.:	**Injury Date:**

To whom this may concern at: **_____ (Name of clinic)**

_____ is being sent to your clinic for evaluation after a

Work-related injury that occurred at the above location.

Injury Description:	**A Drug Screen is** **Not Needed: _____ Needed: _____**

Authorized By: **_____ Signature: _____**

THIS WILL SERVE AS AUTHORIZATION FOR INITIAL EVALUATION AND TREATMENT. PLEASE CALL FOR AUTHORIZATION FOR ADDITIONAL TREATMENT. A COPY OF THIS FORM WILL ALSO SERVE AS AUTHORIZATION FOR PRESCRIPTION MEDICINES.

All medical bills should be forwarded to:

NOTE: The above facility participates in a return to work program that offers modified duty to injured workers on an as needed basis.