

On The Job Injury Procedure:

If an accident occurs at your job site with a temporary employee, our office must be contacted immediately. **Our office numbers are: Sylvania Office 419-882-7646, Monroe Office 734-457-0056 & Southgate Office 734-288-3654, we have a 24 hour Answering Service to collect our calls after 5pm and on weekends.** . Our employees are instructed to inform our office and their supervisor no matter how minor the injury may be.

Our employee should fill out our accident report regardless of necessary medical treatment. **An accident report should be completed within 24 hours of the incident or the discovery of the injury, or immediately if possible.** Any witness to the accident should fill out a witness statement. The employee's supervisor should complete a supervisor report. **We must receive any and all information regarding injury.**

If medical attention is necessary, our preferred medical treatment facilities are:

Lucas County

Concentra Urgent Care – 7010 Spring Meadows Dr. W Ste 101 Holland, OH 43528 (M-F 8am – 5pm)
Concentra Urgent Care – 3028 Navarre Ave Oregon, OH 43616 (M-F 8 am – 5pm)

Monroe County

Corporate Connection 901 N Macomb St Monroe, MI 48162 (M-F 8 am – 4:30 pm)
Dundee Urgent Care 100 Powell Dr #8 Dundee, MI 48162 (M-F 9 am – 9 pm)
Promedica Monroe Regional Hospital 718 N. Macomb St Monroe, MI 48162 (after hours)

Wayne County

Suburban Occupational Health- Romulus 29750 Ecorse Rd. Romulus, MI 48174 (**open 24 hours**)
Concentra – Woodhaven 19200 West Rd Woodhaven, MI 48183 (M-F 7 am – 9 pm Sat 8 am – 4 pm)
Concentra – Romulus 11700 Metro Airport Center Dr Ste 104 Romulus, MI 48174 (24 hr)
Concentra – Allen Park 17500 Federal Dr Ste 750 Allen Park, MI 48101 (M-F 8 am – 5 pm)

However, if emergency medical treatment is necessary, our employee should go to the nearest Emergency Room. Please remind our employee that they work for us, not your facility.

Employee must provide us with any documentation from the medical provider including medical restrictions and/or release to return to work PRIOR to returning to their job.

Encl.
Accident/Injury Report
Witness Statement
Supervisor's Accident Report
Medical Facility Map

ACCIDENT REPORT

NAME _____ SS# _____
 DATE OF INJURY OR EXPOSURE: _____ TIME : _____ (AM)(PM)
 AGE: _____ SEX: _____ M _____ F PHONE NUMBER: _____
 POSITION: _____ LENGTH OF JOB: _____
 JOB SITE LOCATION: _____
 DATE REPORTED: _____ TO WHOM: _____
 WERE YOU WORKING OVERTIME? YES NO
 EXACT LOCATION WHERE INJURY OCCURRED: _____
 JOB OR ACTIVITY BEING PERFORMED AT TIME OF INCIDENT: _____

 FOREMAN OR SUPERVISOR AT TIME OF INCIDENT: _____
 NAMES OF ANY WITNESSES TO INCIDENT: (if none please specify) _____

 DETAILED DESCRIPTION OF EXACTLY HOW INJURY OCCURRED: (if additional space is needed use back side of this form) _____
 _____ WHERE ARE YOU HAVING PAIN (be very specific: _____)

PLEASE CIRCLE THE SPECIFIC PART OF THE BODY INJURED.

FRONT

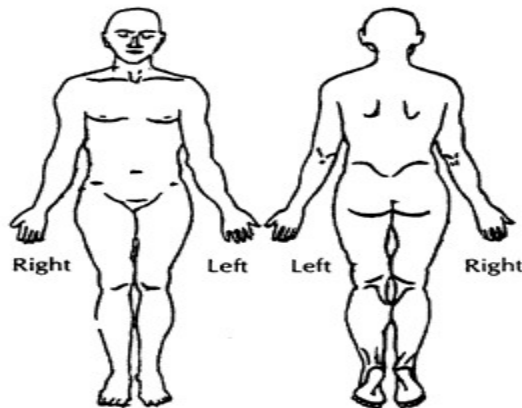
BACK

Right Side

Left Side

Right Side

Left Side



Swelling Pain Burns Cut Crush Scrape Foreign Body

Employee Signature

Date

WITNESS STATEMENT

Injured Worker: _____ **Date of Injury:** _____
Name of Witness: _____ **Department:** _____

Were you in the area where the accident happened? Yes No

Where exactly did the accident happen? _____

What exactly did happen? _____

Was it obvious that the employee was hurt? Yes No

What part of the body was injured (be specific)? _____

Was the employee using a tool or piece of machinery when injured? Yes No

Please describe: _____

Have you ever heard the employee complain of a similar injury or illness? Yes No

Have you ever hear the employee talk about an on-the-job injury before? Yes No

Are you aware of any other accidents, personal or on-the-job, that this employee has had? Yes No

If so, please explain: _____

Are you aware of any outside activities which may have contributed to this condition? Yes No

If so, describe: _____

Are you aware of the individual having problems with this part of the body prior to or subsequent to this injury? If so, please explain: _____

To the best of my knowledge the above questions are answered truthfully, sworn to me this _____ day of _____, 20____.

Printed Name: _____

Witness Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Date of Injury: _____ Time of Injury: _____ AM or PM

Exact Location of Injury: _____

Date Reported to You: _____ By Whom: _____

SUPERVISOR'S ACCIDENT REPORT

Employee Name: _____
Date of Injury: _____ Time of Injury: _____ AM or PM
Exact Location of Injury: _____
Date Reported to You: _____ By Whom: _____

Description of Injury: _____

Specific Body Parts Affected: _____

Was medical treatment sought? _____
Please explain: _____

Are you aware of any other activities this employee may be involved in? Please explain:

Has this employee had similar complaints previously? Please explain: _____

Co-Workers Interviewed (attach statements): _____

What corrective action was taken to prevent similar injury? _____

Supervisor Signature

Date

Print Name

Employee Refusal of Medical Treatment

Were you offered medical treatment for this injury? _____

Reason you are refusing medical treatment at this time:

I do hereby refuse medical treatment offered by my employer for the above stated injury. I have been advised by my Manager/Supervisor that I may seek medical treatment for the injury that may have occurred on the job per the below listed information. I do not think medical treatment is needed at this time, but I will inform my Manager/Supervisor immediately should the need arise.

Employee Signature

Date

Request for Additional Information/Medical Release

Were you treated for this Injury? _____ By whom: _____

Type of Treatment received? _____

Have you ever send a doctor for an injury to this part of your body before? _____

If so where? _____

Describe previous incident/injury: _____

Do you work anywhere other than this company? _____

If so where? _____

What are your family Physicians Names and Address? _____

I, _____, authorize my employer to request and obtain all records regarding any industrial accident/injury or occupational disease involving myself and this employer. This is to include doctor's reports, follow-up reports, nurse's notes, medical bills, test results, etc.

A facsimile or photo copy of this authorization shall be considered as effective and valid as the original. This release shall remain in effect until specifically rescinded by me.

Employee Signature

Date