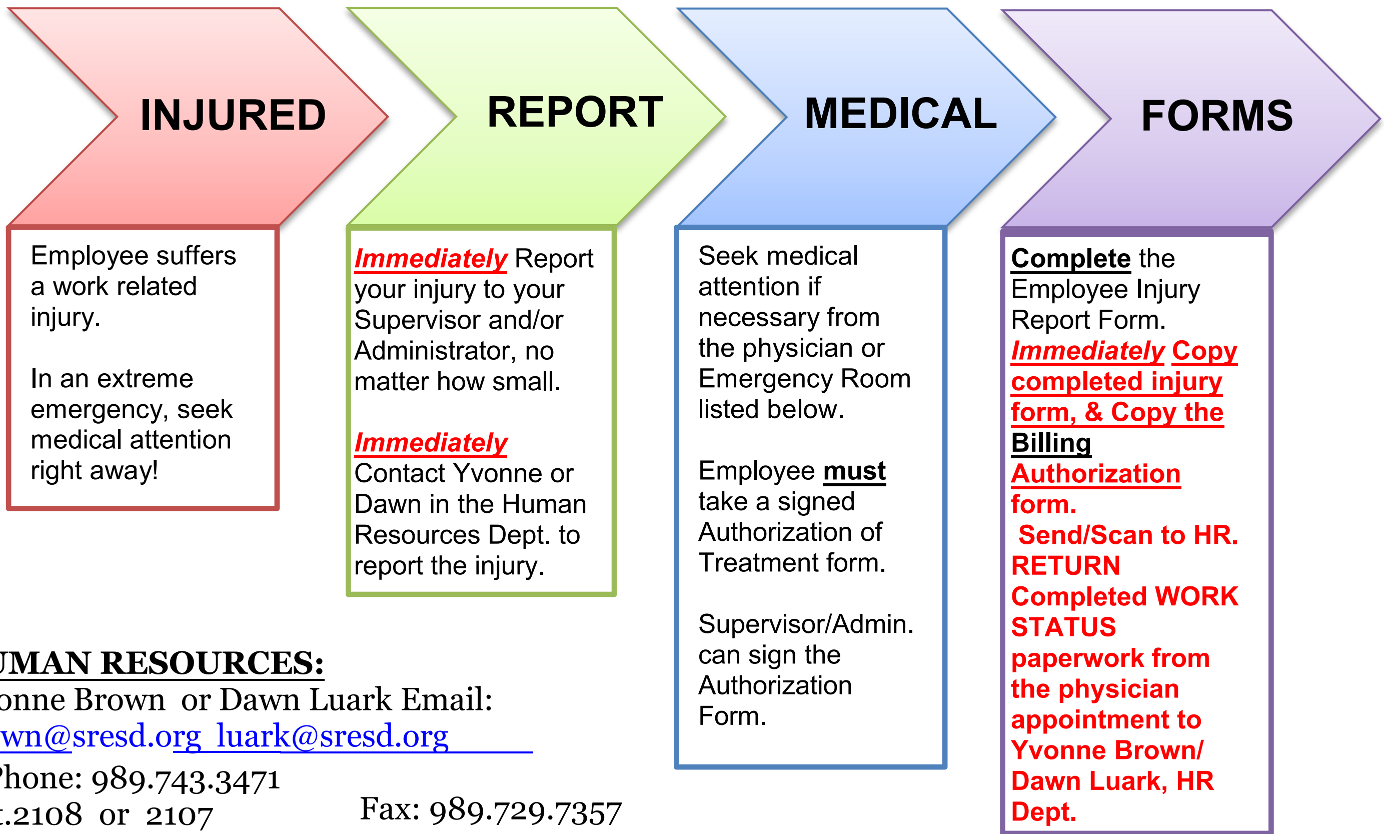
PLEASE FOLLOW DIRECTIONS - KEEP FOR REFERENCE

When Injured At Work….

ATTENTION ALL EMPLOYEES



HUMAN RESOURCES:

Yvonne Brown or Dawn Luark Email:
brown@sresd.org luark@sresd.org
Phone: 989.743.3471
xt.2108 or 2107

Fax: 989.729.7357

DURING NORMAL WORK HOURS VISIT:
Memorial Healthcare Occupational Health - Dr. Vorenkamp

APPOINTMENT REQUIRED
Owosso location Ph: 989.729.2255
100 Health Park Dr., Ste. 101
Owosso MI 48867

DURING OFF WORK HOURS OR IN CASE OF EXTREME EMERGENCY:

Memorial Healthcare/Emergency Room 826 W. King St. Owosso, MI 48867
Ph: 989-723-5211 Fax: 989-729-4972

OR

Visit Memorial Healthcare Urgent Care - Office nearest your location

***UNAUTHORIZED MEDICAL TREATMENT MAY NOT BE ACCEPTED FOR PAYMENT OR REIMBURSEMENT ***

EMPLOYEE'S REPORT OF INJURY

COMPLETE ALL AREAS

PERSONAL INFORMATION

NAME ______ CLAIM # ______

Full ADDRESS ______ HOME/CELL PHONE ______

Gender: ❍ MALE ❍ FEMALE

DATE OF BIRTH ______ SOCIAL SECURITY NUMBER ______

OCCUPATION ______ EMPLOYER ______ DEPARTMENT ______

EMPLOYER ADDRESS ______

NUMBER OF DAYS PER WEEK ______ NUMBER OF HOURS PER DAY ______

LENGTH OF EMPLOYMENT ______ WAGES (HOURLY RATE OF PAY) ______

INJURY INFORMATION

DATE OF INJURY ______ TIME ______ DATE INJURY REPORTED ______

Accident reported to: ______ By (name):______

Who witnessed accident (name for each witness) ______

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: ______

Did you decline/refuse medical treatment YES NO

If Yes Please explain in detail ______

Employee Signature______ Supervisor Signature______

DATE DATE

April 2013