PLEASE FOLLOW DIRECTIONS - KEEP FOR REFERENCE

When Injured At Work....

ATTENTION ALL EMPLOYEES

INJURED

REPORT

MEDICAL

FORMS

Employee suffers a work related injury.

In an extreme emergency, seek medical attention right away! Immediately Report your injury to your Supervisor and/or Administrator, no

matter how small.

Immediately

Contact Yvonne or Dawn in the Human Resources Dept. to report the injury. Seek medical attention if necessary from the physician or Emergency Room listed below.

Employee <u>must</u> take a signed Authorization of Treatment form.

Supervisor/Admin. can sign the Authorization Form.

Complete the Employee Injury Report Form.

Immediately Copy completed injury form, & Copy the

form, & Copy the Billing

Authorization form.
Send/Scan to HR.

RETURN
Completed WORK
STATUS
paperwork from
the physician

appointment to Yvonne Brown/ Dawn Luark, HR Dept.

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

EMPLOYEE'S REPORT OF INJURY

COMPLETE ALL AREAS

PERSONAL INFORMATION

NAME CLAIM # Full address HOME/CELL PHONE Gender: O MALE O 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 INJURY REPORTED DATE OF INJURY TIME 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? O YES O NO When: Did you decline/refuse medical treatment YES If Yes Please explain in detail _ Employee Signature_____ Supervisor Signature_____ DATE DATE