

# SUPERVISOR'S REPORT OF ACCIDENT

## SCHOOL DISTRICT INFORMATION

NAME OF SCHOOL DISTRICT

MAILING ADDRESS

DIVISION

LOCATION

PHONE

## EMPLOYEE INFORMATION

EMPLOYEE'S NAME: FIRST, MIDDLE, LAST

HOME ADDRESS

HOME PHONE

CELL PHONE

☐ MALE ☐ FEMALE

DATE OF BIRTH

GENDER

SOCIAL SECURITY NUMBER

OCCUPATION

DEPARTMENT

## ACCIDENT INFORMATION

DATE OF ACCIDENT

☐ A.M. ☐ P.M.

TIME OF ACCIDENT

REGULAR WORK?

Describe injury:

Body part injured:

Witness info:

Fatality? ☐ YES ☐ NO

How did the accident happen?

Employment date: How long on this job?

Detail all machine or equipment involved:

Specify activity employee was engaged in when accident occurred:

What safety words or safety equipment was in place?

What should be done to prevent repetition?

Has it been done? ☐ YES ☐ NO If not, give reason:

NAME OF PHYSICIAN

ADDRESS

NAME OF HOSPITAL

ADDRESS

## SIGNATURES

SUPERVISOR'S SIGNATURE

DATE

REVIEWED BY

DATE

# EMPLOYEE'S REPORT OF INJURY

## PERSONAL INFORMATION

NAME	CLAIM #	
ADDRESS/CITY	HOME PHONE	CELL PHONE
Gender: <input type="radio"/> MALE <input type="radio"/> FEMALE		
DATE OF BIRTH	SOCIAL SECURITY NUMBER	
OCCUPATION	EMPLOYER	LOCATION
EMPLOYER ADDRESS/CITY		
NUMBER OF DAYS PER WEEK	NUMBER OF HOURS PER DAY	NORMAL DAYS OFF
LENGTH OF EMPLOYMENT	WAGES (HOURLY RATE OF PAY)	

## INJURY INFORMATION

DATE OF INJURY	TIME	DATE INJURY REPORTED
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Accident reported to: \_\_\_\_\_ By (name): \_\_\_\_\_

Who witnessed accident (name & address for each person listed)? \_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

Was your pay continued during any part of your disability? ☐ YES ☐ NO

If so, for what period? \_\_\_\_\_ Last day for which you were paid? \_\_\_\_\_

If not working, date you expect to return to work? \_\_\_\_\_ If you did return to work, list date? \_\_\_\_\_

Do you plan to seek medical treatment? ☐ YES ☐ NO If yes, where? \_\_\_\_\_

Are you still under medical treatment? \_\_\_\_\_ How often do you receive treatment? \_\_\_\_\_

NAME OF DOCTOR	ADDRESS/CITY	PHONE
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## SIGNATURE

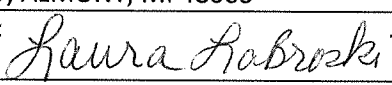
SIGNATURE	DATE	CLAIM #
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# ALMONT COMMUNITY SCHOOLS

## INITIAL AUTHORIZATION TO TREAT FORM

***All additional treatments/services beyond first visit need approval from CCMSI.***

*Employer: please complete this form and send with employee for work-related injury.*

<b>Employee Information</b>		
Name:		Date:
Date of birth:	Social Security number:	
Location where accident/injury occurred:		
Date of injury:	Injured body part(s):	
Brief description of injury/accident:		
<b>Employer Information</b>		
Employer: ALMONT COMMUNITY SCHOOLS		
Phone: 810-673-9104	Fax: 810-798-2367	
Address: 4701 HOWLAND RD, ALMONT, MI 48003		
Authorized signature: 	Printed name & title: LAURA LABROSKI, ACCOUNTANT	
<i>The employer accepts responsibility and authorizes initial treatment, including diagnostic testing, for the employee listed above under a self-insured workers' compensation program managed by a third-party administrator. The employee is to be treated for injuries under the provisions of the Michigan Worker's Disability Compensation Act.</i>		
<b>Billing Information</b>		
Workers' compensation insurance/third-party administrator: Cannon Cochran Management Services Inc. (CCMSI)		
Billing address: 2455 Woodlake Circle, Okemos, MI 48864		
Phone: 517.347.2331	Fax: 217.477.5970	Claim number:
<b><i>All additional treatments/services beyond initial visit need approval from CCMSI. The employer, via CCMSI, will pay related and reasonable charges provided that these charges are accompanied by medical records submitted directly to CCMSI. The patient is financially responsible for all other services unless otherwise authorized.</i></b>		
<b>Medical Clinic</b>		<b>After-hours care</b>
TOTAL CARE PHYSICIANS GROUP URGENT CARE 1834 S. CEDAR STREET, IMLAY CITY, MI 48444 810-721-0000 MONDAY-FRIDAY 9AM-6PM		TOTAL CARE PHYSICIANS GROUP URGENT CARE 1834 S. CEDAR STREET, IMLAY CITY, MI 48444 810-721-0000 MONDAY-FRIDAY 9AM-6PM

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## AUTHORIZATION TO TREAT FORM

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District name: <b>ALMONT COMMUNITY SCHOOLS</b>		
Employee name:		
<b>Medical Diagnosis</b> <i>(to be completed by medical provider)</i>		
Injured body part(s):		
Medical diagnosis:		
Is condition work related? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is employee able to return to work full duty? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is employee fully disabled? <input type="checkbox"/> No <input type="checkbox"/> Yes
If unable to perform full duties, please specify restrictions:		
If employee is fully disabled, what is the estimated time away from work?		
Physician name (please print):		Phone:
Address:		
Physician's signature:		Date:
Date & time of next office visit:		
<b><i>Please note - all additional treatments/services beyond initial visit need approval from CCMSI. The patient is financially responsible for all other services unless otherwise authorized.</i></b>		

When completed, please fax to:

ALMONT COMMUNITY SCHOOLS  
Attn: LAURA LABROSKI  
4701 HOWLAND RD  
Phone: 810-673-9104  
Fax: 810-798-2367