Policy for Reporting Work Related Injuries

When an injury occurs, please notify DecisionHR immediately at (888) 828-5511, Ext. 4101 or 4272. Then complete the following DecisionHR TeleClaim Workers' Compensation Form and fax it to (855) 204-4169. All Employers are required to notify OSHA within 8 hours to report an employee fatality on the job or suffers a work-related hospitalization, amputation, or loss of an eye. Call OSHA's 24 Hour Hotline 1-800-321-6742.

- **If an injury is life threatening:**
  1st – Dial 911 or seek the nearest hospital
  2nd – Notify DecisionHR immediately at the numbers listed above (*)

- **Information needed when reporting an injury:**
  1. Employee name and date of injury
  2. How injury occurred and specific body part injured
  3. Please fax the DecisionHR TeleClaim Workers' Compensation Form to DecisionHR immediately

- **If treatment is needed:**
  1. Direct the injured worker to one of the approved treatment facilities found in the DecisionHR Packet. For assistance in locating a facility, please contact DecisionHR at the phone numbers listed above.
  2. DecisionHR's claims personnel will work with you to determine whether a post-accident drug screen is necessary. Post-accident drug screens will only be administered when it was influenced or caused by a drug related activity. LabCorp offices in your area can be found at www.labcorp.com.
  3. For prescriptions – please see the sticker located on the last page in the DecisionHR Packet.

(*) After Hours: If an injury occurs after hours, leave a message for DecisionHR and include the injury details, your company name, contact person and phone number. Then proceed with necessary medical care and fax the DecisionHR TeleClaim Workers' Compensation Form as explained above. If you need assistance after hours, please call (727) 512-0139.

Important: All injuries are to be reported to DecisionHR within 24 hours of occurrence. Failure to report timely may jeopardize employee benefits and subject employer to penalties by the Division of Workers' Compensation.

DecisionHR TeleClaim Workers' Compensation Form

WITHIN 24 HOURS OF NOTICE FROM INJURED EMPLOYEE:
COMPLETE THIS FORM and CONTACT DECISIONHR AT

(888) 828-5511 ext. 4272 or 4101

Client Company Name: ____

Date of Loss: ________________________ State in which loss occurred: __________________

Employee Information:

1. Employee's Full Name: ____
2. Employee's Social Security Number: ______________________________________

Accident/Incident Information:

1. Date and time of accident: ____
2. Date and time reported to employer: ______________________________________
3. Who was the accident reported to: _______________________________________
4. Employee Supervisor: ____
5. Shift begin and end time: ____
6. Address where accident/incident occurred (street, city, state, zip code and county): __________________
____
____
7. Is the above address the employer's premises? ___Yes ___ No
8. Full description of accident/incident (include what employee was doing, work process, cause, injury and body part): ____
____
____
9. Is the accident/incident questionable to the employer? ___Yes ___ No
10. Was the employee permanently disabled as a result of the accident/incident? ___Yes ___ No
11. Does the employer suspect drug and/or alcohol use at time of accident/incident? ___Yes ___ No
12. Date of death (if accident resulted in a fatality): __________________________
13. Number of days employee is expected to miss (if applicable): __________________
14. Last date worked and time employee left work: ____________________________
15. First date missed: ____
16. Was the employee's salary continued? ___Yes ___ No
17. Has employee returned to work? ___Yes ___ No If yes, what date: ________________
If no, is there an expected return to work date? ___Yes ___ No Date: ________________
18. Does employee have a previous claim? ___Yes ___ No If yes, is the status ___ Open ___ Closed
If yes, please list previous claim body part affected and date of loss: ________________

Accident/Incident Information:

1. Was any safety equipment provided? ___Yes ___ No If yes, was it used? ___Yes ___ No
2. Was an unsafe act being performed? ___Yes ___ No
   If yes, describe: ______________________________
3. Was a machine part involved? ___Yes ___ No
   If yes, describe part: ______________________________
4. Was the machine part defective? ___Yes ___ No
   If yes, in what way? ______________________________
5. Was a third party responsible for the accident/incident: ___Yes ___ No
   If yes, please list third party name, address and phone: ______________________________
   ____
6. Was the accident/incident witnessed? ___Yes ___ No
   If yes, please list witness name, address and phone: ______________________________
   ____
7. Name, address and phone of person to contact regarding additional loss information: ______________
   ____

Provider Information:

1. Was first aid given onsite? ___Yes ___ No If yes, what medical treatment was received? __________
   ____
2. Clinic/Doctor – Doctor name, specialty (i.e.: family prac, chiro, etc.) address, city, St, zip & phone: _______
   ____
3. Hospital name, address, city, St, zip & phone: ______________________________
   ____
   ____
4. Was employee hospitalized? ___Yes ___ No If yes, on what date? ______________________________
5. Was employee: ___ treated-outpatient ___ received for emergency treatment ___ transported by
6. Name of person reporting this claim, including title and phone number: ______________________________
   ____

PLEASE have the Employee sign and date below as an acknowledgement that at this time the Employee has chosen to decline medical treatment:

____

Employee Signature

____

Date