



## **Policy for Reporting Work Related Injuries**

When an injury occurs, please notify DecisionHR immediately at (888) 828-5511, Ext. 4101, 4042 or 4272. Then complete the following DecisionHR TeleClaim Workers' Compensation Form and Email to [CLAIMREPORTING@DecisionHR.com](mailto:CLAIMREPORTING@DecisionHR.com) 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:**

1<sup>st</sup> – Dial 911 or seek the nearest hospital

2<sup>nd</sup> – 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 Client 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](http://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 IN ITS ENTIRETY and CONTACT DECISIONHR AT
Email: CLAIMREPORTING@DecisionHR.com Phone: (888) 828-5511 ext. 4101, 4042 or 4272

Client Company Name: \_\_\_\_\_ Client #: \_\_\_\_\_

Date of Loss: \_\_\_\_\_ State in which loss occurred: \_\_\_\_\_ State EE was Hired: \_\_\_\_\_

Employee Information:

- 1. Employee's Full Name: \_\_\_\_\_
2. Employee's Phone Number: \_\_\_\_\_
3. Employee's Email Address: \_\_\_\_\_
4. Employee's Social Security Number: \_\_\_\_\_
5. Primary Language Spoken: \_\_\_\_\_

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
If so, why? \_\_\_\_\_
10. Does the employer suspect drug and/or alcohol use at time of accident/incident? \_\_\_ Yes \_\_\_ No
11. Date of death (if accident resulted in a fatality): \_\_\_\_\_
12. Last date worked and time employee left work: \_\_\_\_\_
13. First date missed: \_\_\_\_\_
14. Was the employee paid in full on the date of injury? \_\_\_ Yes \_\_\_ No
15. Has employee returned to work? \_\_\_ Yes \_\_\_ No If yes, what date: \_\_\_\_\_
If no, is there an expected return to work date? \_\_\_\_\_
16. Does employee have a previous claim? \_\_\_ Yes \_\_\_ No

**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 ambulance
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***