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. 4272, 4042 or 4101

Client Company Name: _____ Client #: _____

Date of Loss: _____ State in which loss occurred: _____ State Employee 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 and side of the body injured Left or Right):
   (**Example: Employee was coming down from a ladder on a jobsite and slipped and fell to the ground. Injury to the left ankle.)
   _____
   _____
   _____
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?
15. Has employee returned to work? ___Yes ___ No
    If yes, what date: Returned working Full duty or Light Duty? _____
16. If no, is there an expected return to work date? _____
17. Does the 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: ____ treated-outpatient ____ received emergency treatment___ transported by ambulance?
5. **Was employee hospitalized longer than 23 hours? ___Yes ___ No If yes, on what date? _____

****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.**

6. Name of person reporting this claim:
   Printed Name and Title: _____Phone#_____

   Signature: _____Date: _____

Please have the Employee sign and date below as acknowledgement that this claim is being submitted: _____ Employee Signature _____ Date	Please have the Employee sign and date below as acknowledgement that at this time the Employee has chosen to decline medical treatment: _____ Employee Signature _____ Date