Policy for Reporting Work Related Injuries

In the event of a work-related injury, please fill out the DecisionHR Workers' Compensation Claim form in its entirety and submit the form via email, fax or online. **Email:** claimreporting@decisionhr.com; **Fax:** 855 204-4169; **Online:** visit decisionhr.com, navigate to the *Forms* section, and click the link to complete the form electronically. If the injury is severe, immediately notify DecisionHR at 888-828-5511, then proceed in completing the DecisionHR Workers' Compensation Claim Form. For California claims a DWC-1 (Workers' Compensation Claim Form) must be completed **within one day** of your knowledge of the injury/illness. Keep the employer's copy of the DWC-1, provide the injured employee with a copy of the DWC-1, and fax or email a copy of the DWC-1 to DecisionHR.

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

OSHA Reporting

OSHA must be notified within 8 hours of any employee fatality, work related hospitalization, amputation, or loss of an eye.

California employers must notify Cal/OSHA -- www.dir.ca.gov/dosh/report-accident-or-injury.html. All other states must call OSHA's 24-Hour Hotline at 800-321-6742.

If the injury is life threatening

Dial 911 or seek immediate transport to the nearest hospital. Then, notify DecisionHR immediately at 888-828-5511.

For injuries requiring treatment

Direct the injured worker to one of the approved treatment facilities found on the Provider Panel provided to you in the DecisionHR Client Packet or visit www-lv.talispoint.com/login (Username: NLA1236; Password: 1236). On this site you can locate a provider and create a medical card for the employee. For assistance contact DecisionHR at 888-828-5511.

Post-accident drug screening

Post-accident drug screens will only be administered when there is reasonable suspicion that drugs or alcohol were the direct cause of the accident/injury. Please contact DecisionHR prior to requesting a post-accident drug screen.

After hours injury reporting

If an injury occurs after hours, please call 888-828-5511 and leave a message for the workers' compensation department. Please include the injury details, company name, contact person and phone number. Send the employee for any necessary medical care and email or fax the claim form to DecisionHR. If you need immediate assistance after hours, please call 727-512-0139.

DecisionHR TeleClaim Workers' Compensation Form

Date of Injury: _____

Employer/Company Name: _____ Client #: _____

State in which the injury occurred: _____ State Employee was Hired: _____

EMPLOYEE INFORMATION

Employee's Full Name: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employee's Address: _____

Employee's Phone Number: _____ Employee's Email Address: _____

Employee's Social Security Number: _____

Primary Language Spoken: _____

Description of Employee (height, weight, hair color, any distinguishing features):

_____

Employee's Emergency Contact (name and phone number): _____

ACCIDENT/INCIDENT INFORMATION

Date/Time of accident: _____ Date/Time reported to employer: _____

Who was the accident reported to (name and phone number): _____

Employee Supervisor (name and phone number): _____

Shift begin and end time: _____

Address where accident/incident occurred (street, city, state, zip code):

_____

Is the above address the employer's premises? ☐ Yes ☐ No

ACCIDENT/INCIDENT INFORMATION (CONT'D)

Full description of accident/incident (include what employee was doing, work process, cause, injury and body part(s) and side of the body injury [Left or Right]):

_____

_____

_____

Is the accident/incident questionable to the employer? ☐ Yes ☐ No

If yes, why? _____

Does the employer suspect drug and/or alcohol use at time of accident/incident? ☐ Yes ☐ No

Date of death (if accident resulted in fatality): _____

Last date worked and time employee left work: _____

First full day missed from work: _____

Was the employee paid for a full day on the date of injury? ☐ Yes ☐ No

Has employee returned to work? ☐ Yes ☐ No

If yes, what date? _____ Is the employee working: ☐ Full Duty ☐ Modified Duty

If no, is there an expected return to work date? _____

Does employee have a previous claim? ☐ Yes ☐ No

If yes, please provide details: _____

ACCIDENT/INCIDENT DETAILS

Was any safety equipment provided? ☐ Yes ☐ No

If yes, was it used? ☐ Yes ☐ No

Was an unsafe act being performed? ☐ Yes ☐ No

If yes, please describe: _____

Was a machine part involved? ☐ Yes ☐ No

If yes, please describe the machine part? _____

ACCIDENT/INCIDENT DETAILS (CONT'D)

Was the machine part defective? ☐ Yes ☐ No

If yes, in what way? _____

Was a third party responsible for the accident/incident? ☐ Yes ☐ No

If yes, please list third party name, address and phone number: _____

_____

Was the accident/incident witnessed? ☐ Yes ☐ No

If yes, please list witnesses' names and contact information: _____

_____

Are you aware of any prior injuries/problems/pains with this body part for the employee? ☐ Yes ☐ No

If yes, please explain: _____

Have there been any personnel problems or issues with this employee? ☐ Yes ☐ No

If yes, please explain: _____

Are there any reductions in staff taking place at this location? ☐ Yes ☐ No

If yes, please provide details: _____

PROVIDER INFORMATION

Was first aid given onsite? ☐ Yes ☐ No

If yes, what medical treatment was received? _____

Clinic/Doctor Information (name, address, phone number): _____

_____

Hospital Information (name, address, phone number): _____

_____

Was employee: ☐ treated outpatient ☐ received emergency treatment ☐ transported by ambulance

Was employee hospitalized longer than 23 hours? ☐ Yes ☐ No

If yes, on what date? _____

CLAIM REPORTING INFORMATION

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