Accident Report Cover Sheet

Employee Name:_____

Social Security #:_____

Address:_____

_____

Phone Number:_____

D.O.B.:_____

Marital Status:_____

Dependents:_____

Date Employee first started working for Kaye Personnel:_____
(not at incident site, but actually 1st started working for us)

Name of Client where incident occurred:_____

Clients Address:_____

_____

Supervisor at site:_____

Client phone #:_____

Client WC Code:_____

Date Employee Started with this Company:_____

Salary:_____

Days and Hours:_____

Kaye PERSONNEL

ACCIDENT/INJURY REPORT FORM

The Accident/Injury Report form is the initial notification to the Risk Management Dept. that an injury/illness has occurred. It is very important that all the information asked for is provided so that there is an opportunity to determine how the incident occurred and what is required to prevent another occurrence.

If the injured employee is available to fill out the form and sign it, that is the preferred method of completion; however, reporting is not to be delayed because the employee is not available. In the event of serious injury/illness that requires immediate medical treatment, KPI branch personnel may complete the form.

Once the form is complete, please fax, and then mail it to the appropriate Risk Manager for processing. If further information or action is required, you will be contacted.

A file needs to be set up for the claimant and copies of all documentation for the accident kept in the file. Medical records MUST be kept separately.

Keep a copy in the claimant file.

ACCIDENT/INJURY REPORT

COMPANY:_____**BRANCH:**_____

Location of where accident occurred:
Street No./City/State/Zip/Country_____
Did accident occur on employer's premises? (circle one) Yes No?
Department_____Department regularly employed in
_____

Employee: (complete name of injured)_____
Social Security No.:_____**Age:**_____**Sex:**_____**Marital Status:**_____
Employees complete address:_____
Telephone:_____**Language spoken:**_____**Minor Children:**____
Relative or Friend: (name & phone):_____
D.O.I.:_____Day of Week:_____Hour of day _____AM_____PM
First day unable to work:_____AM____PM____Was the injured paid in full for this day? _____When did you or supervisor first know of this injury?_____
Supervisor's Name:_____Occupation when injured:_____
Date of Hire:_____Was this his/her regular occupation?_____
Wages per hour $:_____Worker Compensation Code?_____
Describe in detail how the accident occurred and what the employee was doing when injured:

_____

_____
Machine, tool or object causing the injury?_____
Part of the machine on which accident occurred?_____
Name and addresses of witnesses:_____

_____
Describe the injury in detail and indicate what part of the body was injured:
_____
_____
Probable length of disability:_____
Name and address of physician: (if known)_____
Name and address of hospital: (if known)_____
CORRECTIVE ACTION:_____

_____

Injured Employee's Signature:_____**Date:**_____
Report completed by:_____**Date:**_____

Kaye PERSONNEL

ACCIDENT/INJURY WITNESS STATEMENT FORM

Have any and all witnesses to the incident fill out an Accident/Injury Statement. These can assist in proving or disproving that an incident occurred in the manner in which it was described.

Beware of multiple witnesses returning forms with completely different stories or stories that are exactly the same. Everyone views a situation differently and will remember different details. These are what we need to build an accurate model of what actually occurred.

Please fax, and then mail the form to the Risk Management Dept. Keep a copy in the claimant file.

ACCIDENT/INJURY WITNESS STATEMENT

Injured Employee:_____**Date of Injury:**_____

Name of Witness:_____

Were you in the area where the accident happened? Yes No

Did you actually see the incident occur? Yes No

Describe what you saw and the events that occurred relating to the incident:

_____
_____
_____
_____
_____

Was it obvious to you that the employee was hurt? Yes No

What part(s) of the employee's body was injured?_____
_____

Was the employee using a tool or piece of machinery when injured? Yes No

_____ _____

Witness Signature **Date**

Kaye PERSONNEL

MEDICAL INFORMATION RELEASE FORM

The Medical Information Release Form must be signed by the worker. It will allow us to access records that support the claim. It is not optional.

Please fax, and then mail the form to the Risk Management Dept. Keep a copy in the claim file in your branch office.

MEDICAL INFORMATION RELEASE FORM

By my signature below, I authorize Personnel Management to request and obtain all records regarding any industrial accident or occupational disease involving Kaye Personnel, Inc. and myself. This is to include doctor's reports, follow-up report, nurse's notes, medical bills, test results, etc.

A fax or photocopy of this authorization shall be considered as effective and valid as the original. This release shall remain in effect until specifically rescinded by me.

_____

Print Name

_____ _____

Signature **Date**

Kaye PERSONNEL

ACKNOWLEDGEMENT OF AVAILABLE MODIFIED DUTY FORM

The acknowledgement of Available Modified Duty Form provides documentation of an offer of modified duty to an injured worker with specific medical restrictions. It is very important that this form be completed in a timely manner and that the employee is placed back to work as soon as medically possible. Please be sure the form is completely filled out and a copy is given to the injured worker.

Failure to accept appropriate available modified work will disqualify the employee for indemnity benefits.

Please fax, and then mail the form to the Risk Management Dept. Keep a copy in the claimant file.

ACKNOWLEDGEMENT OF AVAILABLE MODIFIED DUTY FORM

Dear_____

Kaye Personnel desires to provide our injured employees with the most expedient and quality medical care for their work related injuries. Kaye Personnel has developed a modified duty program, that will allow our injured workers to return to work on a modified duty status by making accommodations for work restrictions.

The doctor has advised you that you have been released to modified duty status as of _____. This letter serves as a notice to you that modified duty is available
(Date)
as of_____and you should report to work at_____
(Date) (Location)
at_____AM/PM on this date for_____.
(Time) (Assignment)

Failure to report will be considered an unexcused absence, and you will not be paid for any days missed. Kaye Personnel feels a strong commitment to providing gainful employment to our injured workers during their recovery from work related injuries, and we would appreciate your cooperation.

If you have any questions or concerns, please call your branch manager.

(Circle one)

I accept I decline Modified Duty

_____
Print Name

_____ _____
Signature **Date**

Kaye PERSONNEL

TREATMENT REFUSAL STATEMENT FORM

The Treatment Refusal Statement Form is to be used in conjunction with the Accident/Injury Report Form for those times when an injured worker decides they do not want medical treatment.

An Accident/Injury Report MUST be filled out for every injury/illness. There are no exceptions.

Please fax, and then mail the form to the Risk Management Department. Keep a copy in the claimant file.

TREATMENT REFUSAL STATEMENT

Employee: _____

Date of Injury: _____

Injury: _____

I do hereby refuse medical treatment offered by my employer, kaye Personnel, Inc., for the above stated injury.

_____
Print Name

_____ _____
Signature **Date**

_____ _____
Witnessed **Date**

Kaye PERSONNEL

Injury Investigation Checklist

INJURED EMPLOYEE: _____DATE OF ACCIDENT_____

PERSON COMPLETING CHECKLIST:_____

1. Did you contact and/or confirm accident/injury with supervisor?	**Yes No**
2. Did you have employee sign Request for Medical Treatment, if applicable?	**Yes No**
3. Did you accompany employee to doctor/medical treatment facilities?	**Yes No**
4. Did you have employee sign Release of Medical Information?	**Yes No**
5. Did you get a statement from employee as to nature and extent of accident /injury?	**Yes No**
6. Did employee sign Accident/Injury Report?	**Yes No**
7. Did you take employee SIGNED Drug Screen Authorization and Consent form to job site/medical treatment facilities?	**Yes No**
8. Did you have employee drug screened?	**Yes No**
9. Did you obtain medical report and all important information and documentation from doctor/medical treatment facilities?	**Yes No**
10. Did you discuss and explain your modified duty program to doctor?	**Yes No**
11. Did you request to have medical bills sent to your office?	**Yes No**
12. Did you review with your employee policies and procedures regarding your intention to get them back to work as soon as possible	**Yes No**
13. Did you offer modified duty, if applicable, and have employee sign the Acknowledgement of Available Modified Duty?	**Yes No**
14. Did you complete and forward state required injury report?	**Yes No**
15. Did you create a file or employee accident/injury?	**Yes No**
16. Is this a LOST TIME injury?	**Yes No**
17. Did you conduct an on-site investigation?	**Yes No**

18. Did you discuss with supervisor details of accident and obtain names of witnesses? **Yes No**

19. Did you get statements from all witnesses with information (directly or indirectly) concerning accident/injury? **Yes No**

20. Did you investigate safety measures in force? **Yes No**

21. Did you investigate whether or not equipment or mechanism failure was a factor in accident/injury? **Yes No**

22. Have you reviewed and evaluated all documentation to identify cause? **Yes No**

23. Did you enter this accident/injury on your Accident/Injury Log? **Yes No**

KAYE PERSONNEL, INC.

PANEL OF PHYSICIANS CHECKLIST

EXPLAIN THESE GUIDELINES TO THE INJURED EMPLOYEE. THE COMPANY HAS POSTED A LIST OF FOUR OR MORE MEDICAL DOCTORS OR CLINICS. THESE ARE SEPARATE AND DISTINCT DOCTORS AND DO NOT BELONG TO THE SAME OFFICE OR GROUP PRACTICE. THE INJURED EMPLOYEE IS TO SEEK INITIAL MEDICAL ATTENTION FROM A DOCTOR ON THIS PANEL. THE EMPLOYEE MAY SELECT ANY PROVIDER ON THE LIST AND CHANGE TO ANOTHER PROVIDER ON THE LIST WITHOUT APPROVAL OF THE EMPLOYER/INSURER. FURTHER CHANGES REQUIRE APPROVAL OF THE EMPLOYER. (PLEASE CALL RSCKO TO DISCUSS, OR STATED BOARD OF WORKER'S COMPENSATION, 1-800-283-2318/678-473-3400).

COMPANY MANAGEMENT: I SHOWED THE EMPLOYEE THE POSTED PANEL OF PROVIDERS ON _____(DATE)

_____

SIGNATURE

EMPLOYEE: **I WAS SHOWN THE POSTED PANEL OF PROVIDERS AND DID HAVE EXPLAINED TO ME THE ABOVE GUIDELINES ON_____(DATE)**

_____

SIGNATURE