

YALE PUBLIC SCHOOLS
WORK RELATED INJURY
POLICY AND PROCEDURE
Port Huron Hospital Industrial Health Systems
Revised October 28, 2008

EMPLOYEE INJURY PROCEDURE

- Employee notifies supervisor immediately following any injury.
- Supervisor completes injury report.
- If treatment is required, supervisor will complete a rapid response form, make a copy and provide the original to employee.
- **Employee will be reimbursed for mileage by workers compensation for any travel to pursue treatment related to a work related injury, upon remitting a reimbursement form available in the business office.**

HOW TO FILL OUT RAPID RESPONSE FORM

- Supervisor completes entire form.
- Contact number must be entered on form, not employee telephone number.
- **Supervisor will notify Industrial Health Systems at (810) 982-8016 between the hours of 8:00 a.m. to 4:30 p.m. Monday through Friday**, that employee will be arriving. Supervisor must identify himself by name, employer and job title; State that this is an "I.H.S. Rapid Response call"; Provide the name, date of birth, social security number and injury status of the injured employee.
- **Supervisor will notify Port Huron Hospital at (810) 985-2627 if not between the hours of 8:00 a.m. to 4:30 p.m. Monday through Friday** that employee will be arriving. Supervisor must identify himself by name, employer and job title; State that this is an "I.H.S. Rapid Response call"; Provide the name, date of birth, social security number and injury status of the injured employee
- *No testing will be done until a policy is put into place.*
- Make a copy to submit to Director of Business Services.
- Provide original to employee.
- **Employee will immediately report to Industrial Health Systems or Port Huron Hospital Emergency Room** and provide the Rapid Response form for confirmation of treatment.

INJURIES AFTER NORMAL OFFICE HOURS

- Contact the following people in order listed.
- Building Administrator.
- Greg Manger, Director of Buildings and Grounds
- Beky Silkworth, Director of Business Services
- Employee completes "Rapid Response" form and proceeds to Port Huron for treatment.
- *Employee is to enter contact person's telephone number on form.*
- *No drug or alcohol testing will be done until a policy is put into place.*
- Contact person calls (810) 985-2627 to notify Emergency Center that employee will be arriving and provides employee's name, social security #, date of birth, and injury information.

REFUSAL TO FILE A REPORT OR SEEK TREATMENT

- *It is important to understand that the employer has the right to direct the employee's healthcare for the first 10 days only. If an employee chooses to obtain medical care on his/her own after 10 days, it is at the employee's own risk as to whether workers compensation will approve any or all services.*
- *The refusal to complete an injury report could result in the employee losing any right to workers compensation coverage in the future.*

CCMSI

EMPLOYEE'S REPORT OF INJURY OR ILLNESS

Name _____ Claim # _____

Address _____

Occupation _____ Date of Birth _____ Soc. Sec. # _____

Sex _____ Married or Single _____ Employer _____

Employer's Address _____

Department _____ No. days/per week _____ Normal days off _____

Length of employment _____ Wages (hourly rate of pay) _____ Number hours worked/day _____

COMPLETE THE FOLLOWING IF YOU HAVE DEPENDENT CHILDREN UNDER 21 YEARS OF AGE LIVING WITH YOU

Name of Dependent Child	Age	Name of Dependent Child	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name any dependent children not at least 50% supported by you. _____

INJURY REPORT

Date of injury _____ Time _____ Date injury reported _____

Accident reported to _____ By (name) _____

Who witnessed accident? _____
(Name & Address) _____

Describe fully how injury happened _____

(Continue on back if necessary)

What part(s) of your body were injured? _____

Did you stop work as a result of your accident? Yes No When? _____

Was your pay continued during any part of your disability? _____

If so, for what period? _____ Last day for which you were paid _____

If not working when do you expect to return to work? _____ If you did return what was the date? _____

ILLNESS REPORT (work-related) _____

ALL CLAIMS complete the following:

From whom did you receive first medical treatment? _____ Date of treatment _____

Are you still under medical treatment? _____ How often do you receive treatment? _____

Name of doctor treating you _____

Address of doctor _____ Phone # _____

Signature _____ Date _____

Claim # _____

SUPERVISOR'S REPORT OF ACCIDENT

Company _____ Mailing Address _____

Division _____ Location _____

Employee's Name _____ Soc Sec No _____ Age _____ Sex _____
First Middle Last

Home Address _____ Occupation _____

Date of Accident _____ Time of Accident _____ Department _____
 A.M. P.M. Regular Work? _____

Describe Injury _____ Fatality? No Yes

How Did Accident Happen? _____

Employment Date _____ How Long On This Job? _____

Machine Or Equipment Involved? _____

Unsafe Acts Performed _____

Unsafe Conditions Present _____

What Should Be Done To Prevent Repetition? _____

Has It Been Done? _____ If Not, Give Reason _____

Name of Physician _____ Address _____

Name of Hospital _____ Address _____

Supervisor's Signature _____ Date _____ Reviewed By _____ Date _____