Employee Incident Report Tx

Instructions: 1st Employment employees shall report **ALL** work related injuries, illnesses, or "near misses" events (which could have caused an injury or illness) – no matter how minor. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by employees as soon as possible and given to a 1st Employment Representative for further action. **You can complete this form in the language you feel most comfortable with.**

I'm reporting a work related: ☐ Injury ☐ Illness ☐ Near Miss

Your Name: _____

Job Title: _____

Have you transferred jobs since starting work? ☐ Yes ☐ No If yes, Date of Transfer: _____

On-Site Supervisor: _____

Have you told your On-Site Supervisor about this injury/illness/near miss? ☐ Yes ☐ No

If yes, when did you notify him/her? Date and Time: _____ at _____

When did you notify 1st Employment? Date and Time: _____ at _____

Date of injury/near miss: _____ Time of injury/near miss: _____

Names of witnesses (if any): _____

Where, exactly, did it happen? _____

How would you describe the environment you were working in at the exact time of the accident? Be specific, and please describe noises, smells, equipment, people, etc.

What were you doing before the accident? Be specific.

How did the accident occur? How did you get hurt? Be specific.

What did you do after the accident?

What specific equipment, tools, products, etc. were you handling?

What could have been done to prevent this accident?

What part(s) of your body were injured? If a near miss, how could you, or someone else, have been hurt?

Did you see a doctor about this injury/illness? ☐ Yes ☐ No

If yes, did you get prior approval from 1st Employment? ☐ Yes ☐ No

Date of your doctor's visit: _____ Time: _____

Doctor's name: _____

Doctor's location: _____

Doctor's phone number: _____

Has this part of your body been injured before? ☐ Yes ☐ No

If yes, when and where? _____

Do your have other jobs, including side jobs? ☐ Yes ☐ No

If yes, what is your side job? _____

Do you have any hobbies? ☐ Yes ☐ No

If yes, what is/are your hobby/hobbies? _____

NOTE: Please provide a sketch of the area where the accident occurred with as much details as possible that will help us understand what happened. You can email or drop off the sketch in our office within the next 24 hours.

_____ _____

Employee Signature Date

AUTHORIZATION TO DISCHARGE HEALTH AND/OR MENTAL HEALTH INFORMATION FOR WORKERS' COMPENSATION INVESTIGATION AND CLAIM MANAGEMENT

Patient Name:_____

Health Record No: Unknown Date of Birth:_____ SSN: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

Address:

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

▪**Entire Record, including records from any other medical or health care provider of any kind or source that may be contained within a portion of your files, even though not authored by your physician and/or facility.**

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organizations:

1st Employment Staffing, Inc.
P.O. Box 8712
Fayetteville, AR 72703

Zurich (Work Comp Carrier)
Gallagher Bassett (Claims Management)

For the purpose of: WORKERS' COMPENSATION CLAIM MANAGEMENT

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **This Authorization is valid until Workers' Compensation claim is resolved.**

7. A photostatic copy of this Authorization, or a carbon copy shall be construed as effective and valid as the original and that treatment, payment, or health care operations cannot be denied upon the granting or denial of this organization.

8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

THIS REQUEST ALLOWS YOUR FACILITY TO RELEASE A COMPLETE COPY OF YOUR FILE AND NOT JUST SELECT PORTIONS.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

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Acknowledgement of Available of Modified Duty Work

1st Employment provides our injured employees expedient and quality medical care for their work related injuries. 1st Employment also has a program designed to return injured employees to work by making accommodations for their work restrictions.

If you are advised by the treating doctor that you have been released to modified duty, this letter serves as notice that modified duty is available and you should contact this 1st Employment office immediately. At that time, you will be instructed as to where and when you should report for modified duty.

Failure to report will be considered an unexcused absence, and you will not be paid for any missed days. 1st Employment is committed to providing gainful employment to all of our injured workers during their recovery from work related injuries. We appreciate your cooperation in this matter.

If you should have any questions, please contact your local 1st Employment office.

This offer of available modified duty in no way constitutes an employment agreement and in no way alters 1st Employment's at will employment policy terms and conditions of employment or any other policy of 1st Employment.

I accept ☐ decline ☐ Modified Duty

Employee Signature _____ Date _____