CLIENT ACCIDENT PROCEDURES

WORKERS' COMP. DEPARTMENT
14160 Dallas Parkway, Suite 500
Dallas Texas 75254
PHONE (972) 404-1615
(800) 728-0623
FAX (972) 503-9388

1. If the injury is not serious, call the Workers' Compensation Department first. They can assist in directing to the proper medical facility. A representative will attempt to call the provider prior to treatment being rendered. This will avoid delay in treatment and assure proper billing.

   DO NOT GO TO VOICE-MAIL WHEN REPORTING NEW INJURIES DIAL 0 AND HAVE THE OPERATOR ANNOUNCE OVER THE INTERCOM THAT A "NEW INJURY" IS HOLDING

2. If it is an emergency that requires an ambulance or immediate transport, take care of the employee first, then immediately report the claim to the WC Department. **You need to let the medical provider know that a drug test is required.**

3. If it is the weekend or after business hours, take the injured worker to the nearest medical facility. **Ensure that the provider will conduct a 10-panel drug test. Report the claim on the next business day.**

4. Be certain that in all cases the medical provider understands that the patient is an employee, and that **we require a drug screen for all accidents.** Also the medical provider needs to be aware that **we are able to accommodate any light duty restrictions.**

5. **THE EMPLOYEES INJURY / INCIDENT REPORT NEEDS TO BE COMPLETED AND SIGNED BY THE EMPLOYEE.** We need a Supervisor and Witness Report on each incident. If no witness, please indicate so on the Witness Report. Forms are required on all injuries to be faxed within 24 hours after an injury.

6. **If an employee is released to duty with restrictions, these restrictions must be followed.** If an employee is released to work and then at a later time is taken off work status from a medical provider you need to immediately contact the Workers' Compensation Department to notify us of this disability.

WE MUST GET A FAX OF THE EMPLOYEES WORK STATUS IMMEDIATELY AFTER HIS FIRST VISIT TO ASSURE THAT THEIR DISABILITY PAY STARTS ON TIME. THE LACK OF A STATUS REPORT FROM THE DOCTOR IS THE MOST COMMON REASON FOR DELAY.

WE DO NOT APPROVE TREATMENT UNLESS WE HAVE HEARD FROM SOMEONE IN A SUPERVISORY CAPACITY AT YOUR LOCATION THAT THERE HAS BEEN A JOB RELATED INJURY.

Please help us to help you. These procedures have repeatedly proven to help us protect you and us from frivolous litigation.

EMPLOYEE'S INCIDENT REPORT

COMPLETE ALL BLANKS

Date & Time of injury____

Name of injured worker____________________ **SS#**______________________
Address________________________________ Home Phone________________
Date of Birth_______________ Martial Status _____________ #Dependents__________
Date of hire______________________ **Weekly wages**__________________________
Injury reported to:____________________ Date injury reported______________________
Client where incident occurred____
Address where incident occurred____

Describe the incident in detail (how, why, where, what)_____________________________
____
____

Type of injury (cut, sprain, bruise, fracture, etc.)_____________________________________
Which part of body injured (be specific)____
Are there any safety issues that contributed to this injury? If so, please detail:______________
____
____

List all witnesses to this incident:____
____

List all prior injuries sustained at work and outside of work in the last 10 years that required medical attention (list body parts and dates):____
____
____

I, employee, the undersigned, certify that the above is a true and correct statement of fact and that I made such statements of my own free will. I understand that any payments to me or anyone else for expenses in connection with my accident and resulting injury are not an admission of liability. I authorize full access to copies of medical records, radiology reports, drug/alcohol screenings, and documents of any kind relating to my past or present injury/illness to Risk Management Department. I herby agree to release this information and hold all such medical providers harmless for the release of this information as set forth in this authorization. **"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."**

_________________________ ___________________ ___________________________
EMPLOYEE SIGNATURE **DATE OF REPORT** **TRANSLATED by (if necessary)**

We will prosecute to the fullest jurisdictional extent for all fraudulent claims reported.
A drug test is mandatory on all reported claims.

PLEASE RETURN VIA FAX TO: RISK MANAGEMENT DEPT: (972) 503-9388

EL ACUERDO

Yo e report ado una lesión relacionada con mi trabajo en__________ ______. Estoy rechazando el tratamiento médico en este tiempo. Entiendo que si yo no sigo los procedimientos según lo reflejado en mi acuerdo del empleo, mi lesión puedo no ser cubierto por Worker's Compensation. Yo entiendo que la ley permite que un patrón requiera una pantalla de droga en el plazo de 24 horas de un informe de lesión, y no conformándose con esa ley, yo no se puede cubrir por Worker's Compensation por esta lesión.

Entendido y convenido en_____________, Por: ___________________

Fecha Firma

SS# ____________________

Dia de accidente _________________

AGREEMENT

I, ____________________________________have reported a job related injury on _________________. I am refusing medical treatment at this time. I understand that if I do not follow the procedures as reflected in my employment agreement, my injury may not be covered by Workers' Compensation. I understand that state law allows an employer to require a drug screen within twenty-four hours of an injury report, and by not complying with that law; I may not be covered by Workers' Compensation for this injury.

Understood and agreed on __________, by _____________________________.
Date Signature

Date of injury ________________

Social Security Number ____________________

REPORTE DE LESION / HERIDA
COMPLETE TODA LA FORMA

FECHA Y HORA DE LESION: ______________________________

Nombre Del Empleado Lesionado: ________________________________ **# De Seguro Social:** ______________________________

Direccion: ____ **Telefono de Domicilio:** ______________________________

Fecha de Nacimiento: ___________________ **Estado Civil:** _____ **# de dependientes:** _______ **Sexo: Hombre** ____ **Mujer** ____

Compania donde lesion ocurrio: ____

Direccion Del Lugar Donde Lesion Ocurrio: ____

Describa su lesion detalladamente (como, que se lesiono, donde, y porque ocurrio): ____

____

____

____

Tipo de Lesion (Cortada, Falciada, Contusion, etc.): ____

Locacion del Cuerpo (Mano, Cabeza, Espalda, etc.): ____

Se requirio o se le dio equipo especial protectivo (Lentes Protectivos, Zapatos Especiales, Casco de Fierro)

Si ____ **No** ____ **Por favor indica que clase?** ____

El equipo era usado o se llevaba puesto a la hora de su lesion? Si ___ **No** ___ **Si no, porque?** ____________________________

____

Conose alguna causa de seguridad que contribuya a su lesion? Si es si, explique porfavor: ______________________________

____

Hubo Testigos de su lesion? Si ___ **No** ___ **Si su respuesta es si, escriba los nombres:**

Testigo: ____ **Testigo:** ____

Yo, el empleado, certifico que la declaración hecha aquí es verdad y correcta, y que yo hizo tal declaración por mi propia voluntad. Yo entiendo que cualquier compensación que se me haga a mi o a alguien en conexión con el incidente / lesión no es admisión de responsabilidad por parte de Risk Management Department. Yo doy autorización completo al acceso de datos médicos, reportes de radiografías, prueba de droga/ alcohol. Y toda clase de documentos, pasado o presente, relacionados a mi incidente/lesión. Yo estoy de acuerdo y sostengo a cualquier proveedor medico inocente en el descargo de esta información. Cualquier persona que deliberadamente presente un reclamo falso o fraudulento es culpable de un delito y puede ser propenso a una multa y puede resultar en confinamiento en la prisión del estado

______________________________	______________________________	______________________________
Atestiguado Por	**Fecha de Reporte**	**Firma del Empleado**

Reporte de el Supervisador Completar todos los espacios

Este reported fue llenado en _________ Fecha y Hora del Accidente ______________

Nombre del lastimado (a)______________________ SS#_____________________

Fecha de empleo ___/___/____ Fecha que empleado reporto la lastimacion __/__/______

Occupacion de empleo _________________ Horario de trabajo___________________

Nombre de quien empleado reporto su lastimacion: _____________________________

Nombre de la compania donde se lastimo: ____________________________________

Direccion donde se lastimo: ____

El empleado a perdido dias de el trabajo por causa de su lesion? (Si si, favor de poner to

dias que a perdido, y el dia que regresom, si acaso regreso.)______________________

Descripcion de como paso el accidente (como, porque, donde, que) "Favor de esplicar

con **Detalles**: ____

____

____

Ay una tercera persona envolucrada (otra compania o individual?) que es responsible? Si

si, favor de esplicar y dar detalles: ____

Tipo de lastimacion (cortada, falciada, moreton, fractura, etc.)____________________

Que parte de el cuerpo fue lecionada? (favor de dar detalles)______________________

Hubo cosas de seguridad que contribuyeron a el accidente? Si si, Favor de dar detalles: ___

____

Nombres de testigos: ____

____

Nombre de Hospital/Clinica: ____

Numero de telefono y dereccion de hospital/Clinica ______________________________

____

Usted sabe o a escuchado de alguna informacion que AMS no sabe y debe saber sobre este

reclamo?____

Nombre del Supervisor:____

Firma: ____

Reporte debe de ser completado entre 24 Horas de el accidente !!!!!!!!!

*Favor de asegurarse de que el reporte de el empleado y tentigo sean completas.
Mandar todas las forma completadas al **(972) 503-9388**

SUPERVISOR'S
REPORT OF ACCIDENT

COMPLETE ALL BLANKS

Date of this report_____________________ **Date & Time of injury**________________
Name of injured worker_____________________________ **SS#**_______________________
Date of hire__________________ **Date employee reported incident**____________________
Employee occupation__________________ Hire date____________Time of incident ________
Person employee reported incident to:_______________________________________
Client where incident occurred____
Address where incident occurred____
County_____________________
Has employee lost time from work? (If yes, give dates of lost time and if employee has returned to work) ________
____

Describe the incident in detail (how, why, where, what)____
____
____

Is a third party (another company or individual) responsible for this incident? If yes, please detail_________
____
____

Type of injury (cut, sprain, bruise, fracture, etc.)____
Which part of body injured (be specific)____
Are there any safety issues that contributed to this injury? If so, please detail:________________________
____
____

List all witnesses to this incident:____
____

Name of Medical facility where employee taken______________________________________

Phone # and address of medical provider____

____

Do you know, or have you heard, any information regarding this incident that AMS should know? ________
____
____

Supervisor or Foreman completing this report:_______________________________________
Print name and phone #

Signature____

REPORT DUE WITHIN <u>24 HOURS</u> OF ACCIDENT!!!!!!!!!

*Please ensure that employee incident report and witness statement report are completed

FAX TO RISK MANAGEMENT DEPARTMENT--(972) 503-9388 FAX

WITNESS STATEMENT

COMPLETE ALL BLANKS

Name of Witness_________________________ Date of this report_______________
Employed by_______________________

Name of injured worker_________________________
Date & Time of injury____________
Client where incident occurred______________________________________
Address where incident occurred____________________________________

Are you related to the injured worker?_____
How long have you known the injured worker?_______________

DID you actually see the incident?_________________
Explain, in detail, what you saw or know regarding this incident:_______________
____
____
____
____
____

List names of any other persons who may have information regarding this incident:_______
____
____

Is there any other information that you know that would assist in providing a fair evaluation of this incident?____
____
____

Print name___________________ **Signature**________________________
Phone #:___________________

Please return to Risk Management Department via fax at (972) 503-9388