FIRST REPORT OF INJURY

Date of Report: ______/_____/______

Date Notified Employer: ______/_____/______

Date of Injury: ______/_____/______ Time of Injury: _____:____ AM/PM (circle one)

EDUStaff Employee Information:

Employee Name (Last, First, Middle): ____

SSN: _________-______-_________ DOB: _____/_____/______ Sex: M/F (circle one)

Address (Number & Street): ____

City: ______________________________ State: _________ Zip: ________________

Phone Number: ______-______-_______ **Hire Date: ______/_____/______**

Job Title:____

Injury Report Information:

Job Location: ____

DISTRICT: ____

Start Time: _____:____ AM/PM (circle one) End Time: _____:____ AM/PM (circle one)

Address (Number & Street): ____

City: ______________________________ State: _________ Zip: ________________

Witness to Injury: ____________________Witness Phone Number(s): ______-_____-_______

Explain How Injury Occurred: ____

____

____

Nature of Injury: ____

Part of the body directly affected by the injury: _________________________________

Last Day Worked: ______/_____/_______ Date Employee Returned: ______/_____/_______

Was the injury fatal? Yes/No (circle one) If yes, date of fatality: ______/______/________

Did employee seek medical treatment? Yes/No (circle one)

If yes, date of treatment: ______/______/_________

Name of treatment facility: ____

Address (Number & Street): ____

City: ____________________________________ State: ___________ Zip: ___________________

Restrictions: ____

____

Expected return to work date: ______/______/_______

District Information:

Building Supervisor: ____

(printed name and signature)

Phone Number: ______-______-________

Date: _____________

Feedback:____

____

____

____

____

Please return via email to Julie Powers jpowers@edustaff.org or via fax to 877-974-6339. Thanks!

AUTHORIZATION FOR TREATMENT
Workers Compensation

This form authorizes a health care provider to treat the following EDUStaff Employee:

____

for a work related injury that occurred on ____________________________________

at ____.

Send all billing information to:

Accident Fund
PO Box 40790
Lansing, MI 48901

EDUStaff, LLC Workers Compensation Insurance

Policy Carrier: Accident Fund
Policy Number: WCV6121051