FOR OFFICE USE ONLY

Event No.	Claim No.

EMPLOYEE INJURY REPORT

This report must be sent to Personnel/HR within 24 hours of injury/illness.
See the back of form for further instructions.

PLEASE PRINT AND PRESS FIRMLY – ANSWER ALL QUESTIONS

RETURN TO: P/HR
500 Griswold, 9th Floor
Detroit, MI 48226
Office: (313) 224-5107
or (313)224-0003
FAX: (313) 967-1243
Email: disability@waynecounty.com

1. INJURED EMPLOYEE: _____ **2. SOC.SEC# or last 4.:** _____ - _____ - _____

3. Address: _____ **4. Home Phone:** (_____) _____ - _____

5. Birthdate: _____/_____/_____ **6. Sex/Gender:** ☐ **Male** ☐ **Female** ☐ _____ **7. Marital Status:** ☐ **Married** ☐ **Single**

8. Number of Dependents Under the Age of 16 or Receiving at Least 50% of Support from Injured Employee: _____

9. Department: _____ **10. Division:** _____

11. Job Title: _____ **12. Shift Start Time:** _____ **AM / PM** **13. Work Phone:** (_____) _____ - _____

14. Supervisor: _____ **15. Supv. Phone:** (_____) _____ - _____

16. DATE OF INJURY / ILLNESS: _____/____/____ **Time:** _____ **AM / PM** **17. LAST DAY WORKED:** _____/_____/_____

18. Recurrences or Aggravation of a Previous Injury / Illness? ☐ **Yes** ☐ **No** **If Yes, Date of Original Injury:** _____/_____/_____

19. Did Employee Die? ☐ **Yes** ☐ **No** **If Yes, Date of Death** _____/_____/_____

20. Medical Treatment Required? ☐ **Yes** ☐ **No** **21. Emergency Room Treatment?** ☐ **Yes** ☐ **No** **22. Hospitalized Overnight?** ☐ **Yes** ☐ **No**

23. Location of Accident / Occurrence: (*address, city, bldg. name and type of location, e.g. "locker room," "stairwell," "dock area," etc.*)

_____

24. Describe the Injury / Illness: (*Be more specific than "hurt", "pain" or "sore;" e.g. use "strained back," "chemical burn," etc.*) _____

_____

_____

25. Describe the Body Part Affected: (*Be specific, e.g. "right hand," "left forearm," "lower back," etc.*) _____

_____

26. Describe the Events that Caused the Injury / Illness: (*Be specific, e.g." sprayed with chlorine when gasket broke during replacement," "slipped on wet floor carrying equipment," etc.*) _____

_____

27. Name the Object or Substance Which Directly Injured the Employee: (*e.g. "knife," "band saw," "acid," "floor," etc.*) _____

_____

28. What was the Employee Doing Just Before the Incident? (*e.g. "climbing a ladder, "horseplay", " "computer key-entry," "spraying chlorine from a hand sprayer," etc.*) _____

_____

_____

29. Witness(es): _____

30. Report Date: _____/_____/_____ **Time:** _____ **AM / PM**

AUTHORIZATION FOR MEDICAL TREATMENT

Date: _____/___/_____ **Time:** _____ **AM / PM** **Clinic Name:** _____

Clinic Address: _____

Please give medical treatment to the above Wayne County employee.

This authorization must be signed by a FOREMAN or SUPERVISOR before rendering any medical treatment.

31. Signature of FOREMAN or SUPERVISOR: _____ **Phone:** (_____) _____ - _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This authorization, or photocopy hereof, will authorize a physician, hospital, clinic, or other medical institution to furnish all information they may have regarding my condition while under their observation or treatment, including the history obtained, x-ray and physical findings, diagnosis and prognosis, to the Wayne County Risk Management Division.

32.Signature and Date of Employee: _____

Date: _____/_____/_____

Subject to approval of the Worker's Compensation claim, this form will constitute notice of a leave of absence request pursuant to contractual requirements, personnel procedures, and will be run concurrently with the Family Medical Leave Act if eligibility requirements are met (FMLA Eligibility Notices will be mailed to your home address on file).

33. I acknowledge receipt of a copy of this report: _____

Signature of Employee **Date**

Wayne County

P/HR Disability Administration

EMPLOYEE INJURY REPORT INSTRUCTIONS

1. Employees should report a workplace injury to their supervisor or another designated person e.g. P/HR. as soon as reasonably possible.

2. This report must be completed and submitted to P/HR Disability Administration within 24 hours after receiving information relating to the injury or illness of an employee.

3. This report must be signed by a Supervisor or above and by the injured employee (unless the employee is incapable of signing due to his or her injury or illness).

4. The employee must have the "Authorization for Medical Treatment" signed by the Supervisor or above before receiving any medical treatment.

5. The injury or illness must arise out of and during the course of the employee's employment.

6. The Supervisor or above should not provide authorization for medical treatment to the employee if the injury or illness is not work related.

7. When the Supervisor or above has knowledge that the employee will be disabled for more than seven (7) calendar days, contact P/HR Disability Administration immediately at (313) 224-5107 or (313) 224-0003.

8. All questionable injuries or accidents should be reported on this form. Any additional statements or other information should be provided to assist in the investigation. Please attach supervisor investigation report, witness statements etc.

9. Any questions should be directed to the Workers' Compensation staff in P/HR Disability Administration at (313) 224-5107 or (313) 224-0003.

10. Send original copy of this injury report to:

    Wayne County P/HR Disability Administration
    Guardian Building
    500 Griswold – 9th Floor
    Detroit, Michigan 48226

    Further Distribution: Copy to Treating Facility
    Copy to Injured Employee
    Copy to Employee's Department / Division