EAST CHINA School District

PERSONNEL DEPARTMENT
1585 Meisner Road
East China, MI 48054-4143

PHONE: 810.676.1000
FAX: 810.676.1034
WEBSITE: www.ecsd.us

Dear ECSD Employee:

The East China School District is committed to providing a safe working environment for all employees. Accident and injury prevention are our main goal, but if you are injured while on the job, we want to make sure you receive the care needed to get well again.

We've partnered with St. John's River District Hospital - Occupational Health Center to ensure quality medical treatment and a smooth process for workers' compensation claims. Medical treatment outside of St. John's River District Hospital may **NOT** be eligible for compensation under the state's workers' compensation law.

All employees should be familiar with the steps necessary to seek treatment for injuries occurring at work. Our procedure is listed below.

When an employee is injured:

- Employee reports accident to immediate supervisor
- If it's not an emergency, employee immediately completes an employee report form
- Supervisor immediately emails/faxes the employee report form to the Personnel Office at (810) 676-1034. Within 24 hours, the supervisor should also submit a completed supervisor's report.
- The Personnel Office will provide the employee with a signed initial authorization to treat form. Employees **MUST** take this form to St. John's River District Hospital for initial treatment.
- After the clinic visit, employees should provide a hard copy of the clinic's activity status report to their supervisor.
- St. John's will work with our workers' compensation claim representative to ensure quality of care and approve future visits and prescribed treatments, including physical therapy, diagnostic tests and specialist referrals.
- The Personnel Office will work with employee's supervisor on restricted work options.

If you have any questions or concerns about these procedures or how workplace injuries are managed, please contact the Personnel Office at (810) 676-1033. Once again, we are committed to the safety of all employees. If you have a safety concern or any ideas for safety improvements, please contact your immediate supervisor.

EMPLOYEE/SUPERVISORS ACCIDENT REPORT

CLAIMANTS PERSONAL INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____

ADDRESS _____

HOME PHONE _____ WORK PHONE _____

SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ DATE OF HIRE _____

JOB POSITION _____

MARITAL STATUS _____ NUMBER OF DEPENDANTS _____ ○ MALE ○ FEMALE GENDER

INCIDENT INFORMATION

DATE OF INJURY _____ TIME _____ DATE REPORTED _____ ACCIDENT LOCATION _____

DRIVERS LICENSE # _____ DRIVERS LICENSE STATE _____

Accident description/Summary of incident? _____

WITNESS: NAME _____ PHONE NUMBER _____

What part of the body was injured? _____ Nature of injury? _____

Initial medical treatment: ○ NONE REQUIRED ○ REFUSED ○ FIRST AID ONLY ○ PHYSICIAN/TREATMENT FACILITY VISIT ○ EMERGENCY ROOM VISIT

Location of treatment? _____

TO BE COMPLETED BY SUPERVISOR OF INJURED EMPLOYEE

How did accident happen? _____

Describe injury (include body part): _____

Where did the accident occur? _____

Detail any machine or equipment involved: _____

What was the employee doing prior to the injury? _____

What was the employee doing at the time of the injury? _____

What conditions were present at the time of injury? _____

Was corrective action taken? _____

Has it been done? ○ YES ○ NO If no, give reason: _____

SIGNATURES

EMPLOYEE'S SIGNATURE _____ DATE _____

SUPERVISOR'S SIGNATURE _____ DATE _____

HR USE ONLY:

CLAIM NUMBER _____

DATE RECEIVED _____ DATE SUBMITTED _____

SUPERVISOR'S REPORT OF ACCIDENT

SCHOOL DISTRICT INFORMATION

NAME OF SCHOOL DISTRICT

MAILING ADDRESS

DIVISION | LOCATION | PHONE

EMPLOYEE INFORMATION

EMPLOYEE'S NAME: FIRST, MIDDLE, LAST

HOME ADDRESS

HOME PHONE | CELL PHONE

DATE OF BIRTH | GENDER (O MALE O FEMALE) | SOCIAL SECURITY NUMBER

OCCUPATION | DEPARTMENT

ACCIDENT INFORMATION

DATE OF ACCIDENT | TIME OF ACCIDENT (O A.M. O P.M.) | REGULAR WORK?

Describe injury: _____

Body part injured: _____

Witness info: _____

Fatality? O YES O NO

How did the accident happen? _____

Employment date: _____ How long on this job? _____

Detail all machine or equipment involved: _____

Specify activity employee was engaged in when accident occurred: _____

What safety words or safety equipment was in place? _____

What should be done to prevent repetition? _____

Has it been done? O YES O NO If not, give reason: _____

NAME OF PHYSICIAN | ADDRESS

NAME OF HOSPITAL | ADDRESS

SIGNATURES

SUPERVISOR'S SIGNATURE | DATE

REVIEWED BY | DATE

EAST CHINA School District

Personnel Office
1585 Meisner Road
East China, MI 48054-4143

810.676.1000
810.676.1034 FAX
www.ecsd.us

INITIAL AUTHORIZATION TO TREAT FORM

All additional treatments/services beyond first visit need approval from CCMSI.

Employer: please complete this form and send with employee for work-related injury.

Employee Information		
Name:		Date:
Date of birth:	Last four digits of Social Security Number:	
Location where accident/injury occurred:		
Date of injury:	Injured body part(s):	
Brief description of injury/accident:		
Employer Information		
Employer: EAST CHINA SCHOOL DISTRICT		
Phone: (810) 676-1000	Fax: (810) 676-1034	
Address: 1585 Meisner Road, East China, MI 48054		
Authorized signature:	Printed name & title:	
The employer accepts responsibility and authorizes initial treatment, including diagnostic testing, for the employee listed above under a self-insured workers' compensation program managed by a third-party administrator. The employee is to be treated for injuries under the provisions of the Michigan Worker's Disability Compensation Act.		
Billing Information		
Workers' compensation insurance/third-party administrator: Cannon Cochran Management Services Inc. (CCMSI)		
Billing Address: 2364 Woodlake Drive, Ste. 100, Okemos, MI 48864		
Phone: 517.347.2331	Fax: 217.477.5970	Claim number:
All additional treatments/services beyond initial visit need approval from CCMSI. *The employer, via CCMSI, will pay related and reasonable charges provided that these charges are accompanied by medical records submitted directly to CCMSI. The patient is financially responsible for all other services unless otherwise authorized.*		

Medical Clinic	**After-hours care**
St. John's River District Hospital Occupational Health Center 4100 River Road, East China, MI 48054 810.329.8912 Hours: M-F; 8:00 a.m. – 4:00 p.m.	St. John's River District Hospital Emergency Center 4100 River Road, East China, MI 48054 810.329.7111 24 Hours

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AUTHORIZATION TO TREAT FORM
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District name: East China School District		
Employee name:		
Medical Diagnosis *(to be completed by medical provider)*		
Injured body part(s):		
Medical diagnosis:		
Is condition work related? ☐ No ☐ Yes	Is employee able to return to work full duty? ☐ No ☐ Yes	Is employee fully disabled? ☐ No ☐ Yes
If unable to perform full duties, please specify restrictions:		
If employee is fully disabled, what is the estimated time away from work?		
Physician name (please print):	Phone:	
Address:		
Physician's signature:	Date:	
Date & time of next office visit:		
Please note - all additional treatments/services beyond initial visit need approval from CCMSI. The patient is financially responsible for all other services unless otherwise authorized.		

When completed, please fax to:

East China School District
Attention: Dawn Demick
1585 Meisner Road, East China, MI 48054
Phone: 810.676.1000
Fax: 810.676.1034