Operational Services

Exhibit - Employee and Student Accident or Injury Forms

Employee Accident and Injury Investigation Form

Following all accidents or injuries on the job, the employee must report the incident immediately to their supervisor. **Within twenty-four (24) hours**, this form must be completed by the immediate supervisor and forwarded to Human Resources, 255 E. Lake Street, Suite 300, Bloomingdale Illinois 60108, (630) 894-0490 Fax (630) 894-5960. If medical attention is sought, a Release to Return to Work Form is required.

To be completed by the immediate supervisor only (NOT the employee)

Supervisor conducting investigation: _____ **Title:** _____

Name of affected employee: _____ **Social Security Number:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Job Title: _____ **Location of Employment (school)** _____

Date of Birth: _____ **Male** ☐ **Female** ☐

Date & Time of Injury/Incident: _____ **Did Employee Continue to Work After the Incident Yes** ☐ **No** ☐

Building Location Where Injury Occurred: _____

Witness(s) Yes ☐ **No** ☐ **List Names:** _____

Nature of Injury (*be specific*): _____

What Task was being Performed? _____

How did Accident Occur? _____

_____

_____

Have Medical/First Aid Services been Rendered? Yes ☐ **No** ☐ **Hospitalized?** _____

Name and Address of Physician: _____

Name and Address of Hospital: _____

Did a work place condition or practice contribute to the incident? Yes ☐ **No** ☐ **Is so, what?** _____

Was a Standard of Safe Work Practice Violated? Yes ☐ **No** ☐ **If yes, which one?** _____

_____

Was the unsafe condition or practice corrected immediately? Yes ☐ **No** ☐

If not, what corrective action will prevent a similar recurrence? _____

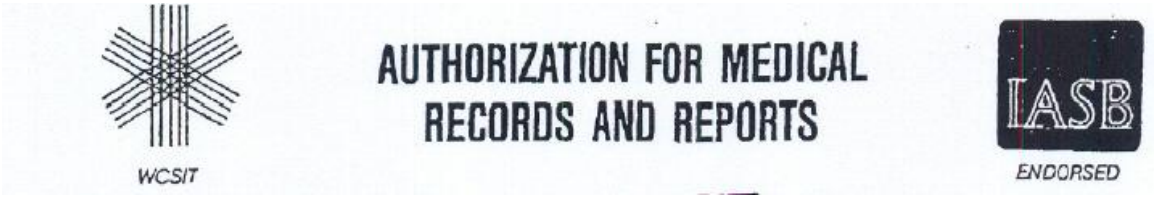
_____

Will an additional Standard of Safe Work Practice be needed? Yes ☐ No ☐ **If so, what?** _____

_____

Signature of Investigator (Supervisor) _____ **Date:** _____

Signature of Injured Worker _____ **Date:** _____



Date: _____

TO WHOM IT MAY CONCERN:

1. The undersigned hereby directs and authorizes (a) any physician, nurse or any other medical practitioner who treated, examined and/or attended me, or (b) any hospital, clinic or medical facility at which I have been treated, examined, attended and/or confined, to verbally confer with and to furnish to any employee, agent, representative or attorney of Hinz Claim Management, INC., all information or opinions pertaining to or concerning the past, current, or future physical, medical or psychological treatment and/or condition of me including, without limitation, any recommendations regarding further care and my ability to perform job duties. This authorization permits the release of any and all records, documents, papers, opinions or statements, whether written or oral, concerning any examination, diagnosis, treatment, periods or stays of hospitalization or other confinements.

2. I understand that the purpose of this authorization is to allow Hinz Claim Management, Inc. to investigate and/or administer claims or potential claims, past, current, or future, for benefits under the Illinois Workers' Compensation or Occupational Diseases Acts. I further understand that this authorization constitutes an express waiver of the patient-physician privilege.

3. A copy of this authorization may be used in place of, and with the same force and effect as, the original. This authorization or any copies thereof shall remain in effect unless and until you receive written notice from me revoking your authority to release the above listed information. This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date it is signed.

_____ _____

Signature *Date*

STUDENT INJURY REPORT

Name of Injured: _____ Date of Birth: _____

Program: ---------- Sex: ----------

Home Address: _____
Street & Number *City* *State*

Date of Injury: _____ Time: _____

Location of Injury on Body: _____

Describe Injury (Be specific): _____

How and Where did Injury Occur? _____

Treatment Given: _____

Person Completing Report: _____

Witness: _____

Notification:

Parent Notification: ---------- Date/Time: _____

Emailed Program Coordinator: ----------

Emailed School Nurse: ----------

Follow up by School Nurse: _____

Added to Policy Manual: 11/2012