Simplifying HR Benefiting Business

Employee:______________________ SSN: ______________________

6 Steps to Follow After An Injury Has Occurred

1. Complete the Accident Investigation Form (Employee Accident/Injury Questionnaire)

2. Contact **Kathy Cisson @ Quality Business Solutions:**
   Email: kathy@qualitybsolutions.net
   Phone 864/660-6954
   Fax 864/660-6974

3. If medical attention is needed please use your provider list to direct treatment for the injured employee.

4. **AS SOON AS POSSIBLE**—Fax/Email the Employee Accident/Injury Questionnaire and Employer Report of Accident **WITHIN 24 hours** of the injury to Kathy Cisson

5. Fax/Email all medical documents to Kathy. Paperwork from all appointments until released by the doctor.

6. Contact Kathy Cisson of missed doctor appointments. Kathy needs to know days missed and the date the employee returns to work after an injury has occurred to modified duty or regular work.

kathy@qualitybsolutions.net
Phone 864/660-6954
Fax 864/660-6974

Simplifying HR Benefiting Business

REPORT ALL WORK RELATED INJURIES IMMEDIATELY

Delay in reporting can jeopardize work comp benefits

1) To your supervisor/manager

2) Kathy Cisson @ QBS
Phone 864/660-6954
Fax 864/660-6974
Email: kathy@qualitybsolutions.net

COMPLETE PAPERWORK AND EMAIL KATHY CISSON WITHIN 24 HOURS OF INJURY OR NEXT BUSINESS DAY

Simplifying HR Benefiting Business

Following is an explanation of forms that are used in reporting/monitoring workers' compensation injuries. When reporting please provide supervisor/manager contact name and telephone number.

Employee Accident/Injury Questionnaire – Injured worker must complete his/her version of the occurrence. All questions on the form MUST be answered in order to give the adjuster accurate information. This form must be signed and dated by **employee.**

Witness Statement – Have the witness complete, sign and date as soon as possible after the incident. This form must be signed and dated.

Documentation Form – Please document **ALL** conversations regarding the injury as well as, the date of conversation, the person you spoke with and what was discussed during the conversation.

Authorization for Treatment – Send this form to the work comp doctor on the first visit after an injury occurs. It has the information that the doctor's office will need including my name and number to contact me for authorization. I will give the doctor's office the workers comp information.

Medical Release Form - Injured worker must sign if they refuse medical treatment.

Provider List - Present to injured worker at the time of the incident. They **MUST** seek medical treatment from doctor on the list. If no provider list included in your packet of information, go to nearest **Doctor's Care/Urgent Care or walk in facility** in your area.

Simplifying HR Benefiting Business

EMPLOYEE ACCIDENT / INJURY REPORT

Restaurant #:______________________________

Name ____ Social Security # ________________
First Middle Last

Address____

Employee Ph #____

Manager on Duty:_________________________________ Phone #__________________________

What was employee doing just before the incident occurred?

____

____

____

Details of Incident:____

____

Did employee seek medical treatment? If yes, where:_________________________________

____

When is employee scheduled to work ____

Witness Name:____________________________ PH#______________________________

Other employees on duty at time of the incident:___________________________________

____

Authorization to Release Information: I hereby authorize any physician, hospital or other person or institution to permit the Insurance Company or its representative to examine, make or be furnished with any information concerning illness or injury sustained by me. This includes treatment, consultations, medical history, hospital records, prescriptions, diagnosis or findings. A photo static copy of this authorization shall be considered as valid as the original.

Employee Signature _______________________________________ Date _____________________

Simplifying HR Benefiting Business

WITNESS STATEMENT

Name:____

Address:____

Phone#:____________________

Date of Injury:_______________Time:________________

Person Injured:____________________________________

Details of what you witnessed: ____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

______________________________ ____________________

Witness Signature Date

Documentation Form

Simplifying HR Benefiting Business

Date:____________
RE: ________________________ Spoke With:__________________________

Documentation:____

____

____

____

____

Date:____________
RE: ________________________ Spoke With:__________________________

Documentation:____

____

____

____

____

Date:____________
RE: ________________________ Spoke With:__________________________

Documentation:____

____

____

____

____

____

AUTHORIZATION FOR TREATMENT

Please call physician office for instructions prior to sending employee to them.

Date: ____________________

Employee Name: ____________________________
Company Name: ____________________________
Company Phone Number: 864-660-6954

Co. Rep. Authorizing Treatment: Kathy Cisson
(print)

____
(signature)

Date of Injury: ______________ **Part of Body Injured:** ______________

Services Requested: (please check)

X Injury Care

X Drug Screen – 5 panel

Modified Work Available: X Yes ____ No

Employer Information:

Kathy Cisson
Quality Business Solutions, Inc.
280 Hindman Road
Travelers Rest, SC 29690
Phone: 864/660-6954
Fax: 864/660-6974
kathy@qualitybsolutions.net

Work Comp Billing Information:
Contact Kathy Cisson for Work Comp information

PLEASE CONTACT KATHY CISSON FOR INITIAL EVALUATION AUTHORIZATION

Simplifying HR Benefiting Business

MEDICAL RELEASE

SIGN ONLY IF TREATMENT IS DECLINED

I,________________________________, HAVE BEEN ADVISED BY MY SUPERVISOR (OR PERSON IN CHARGE) TO SEEK MEDICAL TREATMENT AT OUR WORKERS' COMPENSATION DOCTOR.

I AM HEREBY DECLINING TO SEEK MEDICAL TREATMENT AND I UNDERSTAND BY DOING SO, I AM RELEASING QUALITY BUSINESS SOLUTIONS OF ANY FURTHER RESPONSIBILITY PERTAINING TO THIS INJURY.

____ / ________________

EMPLOYEE SIGNATURE DATE

____ / ________________

MANAGER SIGNATURE DATE

kathy@qualitybsolutions.net

280 Hindman Road, Travelers Rest, SC 29690
Phone (864) 660-6954 Fax (864) 660-6974