

SUPERVISOR'S REPORT OF ACCIDENT

(PLEASE READ AND FOLLOW INSTRUCTIONS ON BACK)

EVERY ACCIDENT SHOULD BE INVESTIGATED AND THE CAUSES CORRECTED SO THAT MORE ACCIDENTS WILL NOT OCCUR. DO NOT OVERLOOK THE SO-CALLED "UNIMPORTANT" CASES, BECAUSE, EXCEPT FOR "CHANCE" THEY COULD ALSO HAVE BEEN SERIOUS. IT IS ONLY BY THOROUGH INVESTIGATION THAT MANY OF THE REAL CAUSES CAN BE DETERMINED AND CORRECTED.

NAME OF EMPLOYEE _____ COMPANY _____ DEPT. _____

DATE OF ACCIDENT _____ TIME _____ DID EMPLOYEE LOSE TIME FROM WORK? YES NO

HOURS LOST ON DATE OF ACCIDENT _____ HAS EMPLOYEE RETURNED TO WORK? YES NO

JOB TITLE _____ SERVICE WITH THE COMPANY _____ YEARS IN PRESENT JOB _____

GIVE US YOUR HONEST COMMENTS ON QUESTIONS BELOW. WE ARE NOT TRYING TO BLAME ANYONE. YOUR OPINION MAY HELP US PREVENT ACCIDENT REPETITION.

PLEASE ANSWER THE FOLLOWING:

CHECK "YES" OR "NO"

- | | | |
|--|------------------------------|------------------------------|
| 1. WAS INJURED PERSON PROPERLY INSTRUCTED IN SAFE AND EFFICIENT METHODS? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. DID INJURED PERSON VIOLATE ANY INSTRUCTIONS? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 3. WAS NECESSARY PROTECTIVE EQUIPMENT WORN? (IF APPLICABLE) | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 4. DID POOR HOUSEKEEPING CONTRIBUTE TO INJURY? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 5. DID HORSEPLAY CAUSE THE INJURY? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 6. WAS IT CAUSED BY SOMETHING WHICH NEEDED REPAIRS? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 7. SHOULD A GUARD BE PROVIDED? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 8. DID ANY BODILY DEFECT CONTRIBUTE TO INJURY? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 9. WAS IT CAUSED BY AN UNSAFE ACT? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 10. DID INJURED REPORT THE INJURY TO YOU, THE SUPERVISOR, IMMEDIATELY? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

ACCIDENT. (DESCRIBE WHAT INJURED WAS DOING AT TIME OF ACCIDENT, WHAT HAPPENED, WHO WAS INVOLVED, NATURE OF INJURY, PART OF BODY AFFECTED) _____

WITNESSES' NAMES _____

UNSAFE ACTS. (WHAT DID THE EMPLOYEE OR ANOTHER PERSON DO INCORRECTLY?) _____

UNSAFE CONDITIONS. (WHAT UNGUARDED OR UNSAFE CONDITION OF MACHINERY, EQUIPMENT, BUILDING OR PREMISES WAS INVOLVED?) _____

ACTIONS TAKEN. (WHAT DID YOU DO TO CORRECT THE CONDITIONS WHICH CAUSED THIS INJURY?) _____

REMEDIES. (WHAT SHOULD YOUR ORGANIZATION DO TO PREVENT OTHER INJURIES LIKE THIS?) _____

MEDICAL CARE. DID EMPLOYEE GO TO DOCTOR OR HOSPITAL? YES NO IF YES, COMPLETE THE FOLLOWING

NAME OF DOCTOR OR HOSPITAL _____ DATE OF INITIAL VISIT _____

ADDRESS _____ TELEPHONE NUMBER _____

AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION? YES NO

REASONS WHY _____

REPORT SUBMITTED BY _____ DATE _____



**INDIANA WORKER'S COMPENSATION
FIRST REPORT OF EMPLOYEE INJURY, ILLNESS**

State Form 34401 (R9 / 03-01)

Please return completed form electronically by an approved EDI process

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

FOR WORKER'S COMPENSATION BOARD USE ONLY

Jurisdiction	Jurisdiction claim number	Process date
--------------	---------------------------	--------------

PLEASE TYPE or PRINT IN INK

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Occupation/Job title	NCCI class code
Name (last, first, middle)		Marital status <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	Date hired	State of hire
Address (number and street, city, state, ZIP code)			Hrs/Day	Days/Wk
Telephone number (include area code)		Number of dependents	Wage Per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month \$ <input type="checkbox"/> Year <input type="checkbox"/> Other	
Employee status <input type="checkbox"/> Paid Day of Injury <input type="checkbox"/> Salary Continued				

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC Code	Insured report number
Address of employer (number and street, city, state, ZIP code)	Location number	Employer's location address (if different)	
	Telephone number	Carrier/Administrator claim number	
Actual location of accident/exposure (if not on employer's premises):		Report purpose code	

CARRIER/CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate <input type="checkbox"/> Self-Insurance
Address of claims administrator (number and street, city, state, ZIP code)	<input type="checkbox"/> Insurance Carrier	Policy/Self-insured number
	<input type="checkbox"/> Third Party Admin	Policy period From _____ To _____
Telephone number	Code number	
Name of agent		

OCCURRENCE/TREATMENT INFORMATION

Date of Inj /Exp	Time of occurrence <input type="checkbox"/> AM <input type="checkbox"/> PM	Date employer notified	Type of injury/exposure	Type code
Last work date	Time workday began	Date disability began	Part of body	Part code
RTW date	Date of death	Injury / Exposure occurred on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of contact	Telephone number
Department or location where accident / exposure occurred		All equipment, materials, or chemicals involved in accident		
Specific activity engaged in during accident/exposure		Work process employee engaged in during accident / exposure		
How injury / exposure occurred Describe the sequence of events and include any relevant objects or substances				Cause of injury code
Name of physician / health care provider			INITIAL TREATMENT	
Name of witness	Telephone number	Date administrator notified	<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Minor. By Employer <input type="checkbox"/> Minor: Clinic / Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/> Future Major Medical / Lost Time Anticipated	
Date prepared	Name of preparer	Title	Telephone number	

An employer's failure to report an occupational injury or illness may result in a \$50 fine (IC 22-3-4-13).

**AUTHORIZATION FOR RELEASE OF
MEDICAL, MILITARY, EDUCATION AND WAGE INFORMATION**

To any physician, dentist, hospital, health care practitioner, military authority, education authority, employer or insurance carrier:

The requested information is needed to accurately evaluate, adjust and pay the patient's insurance claim.

I hereby authorize any health care professional (including health care physicians, medical practitioners or other health care providers, hospitals, medical attendants, nurses, x-ray technicians, or any other person), military authority, education authority, employer or insurance carrier, to furnish to the insurance company named above or its authorized vendors and representatives, wage loss and individually identifiable health information regarding my injuries, payment, treatment rendered, or health care received or provided. I understand that this authorization is voluntary.

I agree that a photocopy or fax of the original authorization shall have the same force and effect as the original.

I understand that my health care records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that I may revoke this authorization at any time by notifying the health care professional(s) in writing, but if I do it will not have any affect on any actions taken before receipt of the revocation.

I understand that once disclosed, the information and documentation released may be re-disclosed and may no longer be subject to the HIPAA Privacy Rule.

This disclosure is made at the request of the individual named below for the purposes of evaluation, adjusting and paying an insurance claim.

Unless otherwise required by law, this authorization shall expire upon the final resolution of the insurance claim.

By signing below, the patient acknowledges that he/she has read the fraud statement printed below.

PATIENT OR REP SIGNATURE	PATIENT ADDRESS	
PATIENT NAME OR REP (PLEASE PRINT)	CITY, STATE, ZIP	
	PATIENT PHONE NUMBER	
REPRESENTATIVE'S RELATIONSHIP TO PATIENT	SOC SEC NUMBER	DATE OF BIRTH

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION COMMITS A FELONY.

**CITY OF WHITING
MEDICAL CARE VERIFICATION FORM**

Instructions:

This form must be completed in its entirety whenever the employee is required to comply with the City of Whiting Personnel Policy, department work rules or terms of any collective bargaining agreement requesting verification of medical care (doctor's certificate). The employee must complete and sign Section 1 before presenting the form to their physician who must then complete Section 2.

SECTION 1: TO BE COMPLETED BY THE EMPLOYEE

Employee name:

Date(s) of absence(s):

I authorize the release of the information requested on this form to my employer to verify a medical care absence (sick leave) requiring time off from work.

Employee signature:

SECTION 2: TO BE COMPLETED BY THE PHYSICIAN

Physician's name (printed):

Physician's phone number:

Date(s) under Physician's care:

Is this an FMLA covered absence?

If yes, please complete a City of Whiting FMLA Certification form and attach.

The above listed employee was under my medical care for the date(s) listed in Section 2 above for an illness or injury that prevented him/her from performing his normal employment duties:

Physician's signature:

Failure to complete this form in its entirety may result in the loss of medical leave (sick leave) benefits and disciplinary action for the employee.

WARNING:

Submission of a fraudulent or false Medical Care Verification Form is a serious offense and will result in the termination of the employee.



7501 West 15th Avenue □ Gary, IN 46406
Ph 219-977-2090 □ Fax 219-977-2091
www.compcareonline.com

Date: _____

Hours: Mon – Fri 8 am – 6 pm Sat 8 am – 12 Noon
Last Drug Screen one hour before closing, please

AUTHORIZATION FORM

Employee Name _____

Company Name: **City of Whiting** Department: **Fire Department**

Company Address: **1916 Schrage Avenue – Whiting Indiana 46394**

Phone Number: **219-659-1069** Fax Number **219-473-7572**

Authorizing Supervisor: Michael J. Mantich Email: mmantich@whitingindiana.com

Please render the following services:

- | | |
|---|---|
| <input type="checkbox"/> Executive Physical by Appointment | <input type="checkbox"/> Blood Lead w/ ZPP |
| <input type="checkbox"/> Diagnosis and Treatment | <input type="checkbox"/> Blood Lead w/o ZPP |
| <input type="checkbox"/> Return to Work Exam | <input type="checkbox"/> Immunization (Hep B, Tetanus...) |
| <input type="checkbox"/> DOT Physical | <input type="checkbox"/> Pulmonary Function Testing |
| <input type="checkbox"/> General Physical/Non DOT | <input type="checkbox"/> Audiometric Testing |
| <input type="checkbox"/> DOT Drug Screen 5 Panel* | <input type="checkbox"/> Diagnostic X-Ray |
| <input type="checkbox"/> Non DOT Drug Screen 10 Panel* | <input type="checkbox"/> EKG/Stress Testing |
| <input type="checkbox"/> Non DOT Drug Screen 10 Panel with Alcohol* | <input type="checkbox"/> Other |
| <input type="checkbox"/> BAT (Breath Alcohol Test)* | _____ |
| <input type="checkbox"/> Collection Only* | |
| <input type="checkbox"/> Hair Collection | |

***Please Check One for drug Screen**

- Pre-Employment
- Random
- Post Accident
- Reasonable Suspicion

RESULTS – PLEASE CHECK ONE

Fax Mail Phone

For emergency services after 6 pm refer to one of the following hospitals with instructions to call:
Dr. Michael Foreit , Dr. Frank Messana or Dr. Keith Nalley with all follow-up treatment to be done at Comprehensive Care

<i>Area Hospitals:</i>	St Margaret Mercy 5454 Hohman Ave Hammond, IN 46320 (219) 932-2300	Community Hospital 901 MacArthur Blvd Munster, IN 46321 (219) 836-1600	St. Catherine Hospital 4321 Fir Street East Chicago, IN 46312 (219) 392-1700	Methodist Northlake 600 Grant Street Gary, IN (219) 981-4500
------------------------	---	---	---	---