THE ADVANCE GROUP

On The Job Injury Procedure:

If an accident occurs at your job site with a temporary employee, our office must be contacted immediately. **Our office numbers are: Sylvania Office 419-882-7646, Monroe Office 734-457-0056 & Southgate Office 734-288-3654, we have a 24 hour Answering Service to collect our calls after 5pm and on weekends. .** Our employees are instructed to inform our office and their supervisor no matter how minor the injury may be.

Our employee should fill out our accident report regardless of necessary medical treatment. **An accident report** should **be completed within 24 hours of the incident or the discovery of the injury, or immediately if possible.** Any witness to the accident should fill out a witness statement. The employee's supervisor should complete a supervisor report. **We must receive any and all information regarding injury.**

If medical attention is necessary, our preferred medical treatment facilities are:

<u>Lucas County</u>
U.S. Healthworks – Holland 7010 Spring Meadows Dr. W Ste 101 Holland, OH 43528 (M-F 8am – 6 pm)
U.S. Healthworks – Oregon 3028 Navarre Ave Oregon, OH 43616 (M-F 8 am – 6 pm)

<u>Monroe County</u>
Corporate Connection 901 N Macomb St Monroe, MI 48162 (M-F 8 am – 4:30 pm)
Dundee Urgent Care 100 Powell Dr #8 Dundee, MI 48162 (M-F 9 am – 9 pm)
Promedica Monroe Regional Hospital 718 N. Macomb St Monroe, MI 48162 (after hours)

<u>Wayne County</u>
Concentra – Woodhaven 19200 West Rd Woodhaven, MI 48183 (M-F 7 am – 9 pm Sat 8 am – 4 pm)
Concentra – Romulus 11700 Metro Airport Center Dr Ste 104 Romulus, MI 48174 (24 hr)
Concentra – Allen Park 17500 Federal Dr Ste 750 Allen Park, MI 48101 (M-F 8 am – 5 pm)

After hours, injuries are treated in the emergency room
However, if emergency medical treatment is necessary, our employee should go to the nearest Emergency Room. Please remind our employee that they work for us, not your facility.

Employee must provide us with any documentation from the medical provider including medical restrictions and/or release to return to work PRIOR to returning to their job.

Encl.
Accident/Injury Report
Witness Statement
Supervisor's Accident Report
Medical Facility Map

THE ADVANCE GROUP

ACCIDENT REPORT

NAME____SS#_____________________________

DATE OF INJURY OR EXPOSURE: __________________________TIME :________(AM)(PM)

AGE: ________SEX:______M________F PHONE NUMBER: ___________________________

POSITION: _________________________________LENGTH OF JOB: ________________

JOB SITE LOCATION: ____

DATE REPORTED: ________________________TO WHOM: ____________________________

WERE YOU WORKING OVERTIME? ☐ YES ☐ NO

EXACT LOCATION WHERE INJURY OCCURRED: __________________________________

JOB OR ACTIVITY BEING PERFORMED AT TIME OF INCIDENT: ____________________

____

FOREMAN OR SUPERVISOR AT TIME OF INCIDENT: _______________________________

NAMES OF ANY WITNESSES TO INCIDENT: (if none please specify) __________________

____

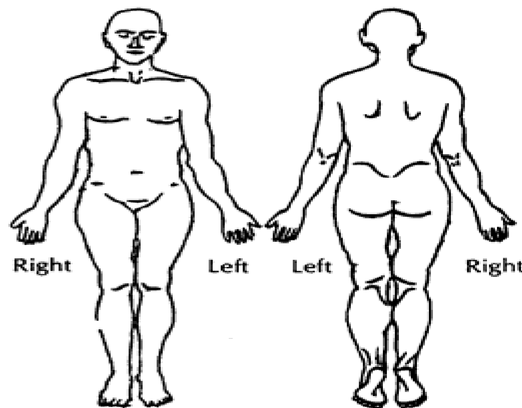
DETAILED DESCRIPTION OF EXACTLY HOW INJURY OCCURRED: (if additional space is needed use back side of this form) ____

____WHERE ARE YOU HAVING PAIN (be very specific: __________________________________

PLEASE CIRCLE THE SPECIFIC PART OF THE BODY INJURED.

FRONT **BACK**

☐ Right Side ☐ Left Side ☐ Right Side ☐ Left Side



☐ Swelling ☐ Pain ☐ Burns ☐ Cut ☐ Crush ☐ Scrape ☐ Foreign Body

______________________________ ________________________

Employee Signature Date

THE ADVANCE GROUP

WITNESS STATEMENT

Injured Worker: ________________________ **Date of Injury:** __________________________
Name of Witness: _______________________ **Department:** ___________________________

Were you in the area where the accident happened? Yes ☐ No ☐
Where exactly did the accident happen? ____
What exactly did happen? ____
____
____
Was it obvious that the employee was hurt? Yes ☐ No ☐
What part of the body was injured (be specific)? ____
____
Was the employee using a tool or piece of machinery when injured? Yes ☐ No ☐
Please describe: ____
Have you ever heard the employee complain of a similar injury or illness? Yes ☐ No ☐
Have you ever hear the employee talk about an on-the-job injury before? Yes ☐ No ☐
Are you aware of any other accidents, personal or on-the-job, that this employee has had?
Yes ☐ No ☐
If so, please explain: ____
Are you aware of any outside activities which may have contributed to this condition?
Yes ☐ No ☐
If so, describe: ____
Are you aware of the individual having problems with this part of the body prior to or subsequent to this injury? If so, please explain: ____
____

To the best of my knowledge the above questions are answered truthfully, sworn to me this _____ day of ____________, 20___.

Printed Name: ___________________________________

Witness Signature: ______________________________________Date:______________________

Supervisor Signature: ____________________________________Date: ____________________
Date of Injury:____________________Time of Injury:________________AM or PM
Exact Location of Injury:____
Date Reported to You:____________________By Whom:___________________________

THE ADVANCE GROUP

SUPERVISOR'S ACCIDENT REPORT

Employee Name: ____
Date of Injury: ___________________ Time of Injury: _______________ AM or PM
Exact Location of Injury: ____
Date Reported to You: ___________________ By Whom: _________________________

Description of Injury: ____
____
____
____
Specific Body Parts Affected: ____
____
Was medical treatment sought? ____
Please explain: ____
____
Are you aware of any other activities this employee may be involved in? Please explain:
____
____
Has this employee had similar complaints previously? Please explain: _______________
____
Co-Workers Interviewed (attach statements):____________________________________
____
What corrective action was taken to prevent similar injury? ________________________
____

____ ______________________
Supervisor Signature Date

____
Print Name

THE ADVANCE GROUP

Employee Refusal of Medical Treatment

Were you offered medical treatment for this injury? ___________________________________
Reason you are refusing medical treatment at this time:
____

I do herby refuse medical treatment offered by my employer for the above stated injury. I have been advised by my Manager/Supervisor that I may seek medical treatment for the injury that may have occurred on the job per the below listed information. I do not think medical treatment is needed at this time, but I will inform my Manager/Supervisor immediately should the need arise.

____________________________ ______________________
Employee Signature Date

Request for Additional Information/Medical Release

Were you treated for this Injury? _____________ By whom: _________________________
Type of Treatment received? ____
Have you ever send a doctor for an injury to this part of your body before? _________________
If so where? ____
Describe previous incident/injury: ____
Do you work anywhere other than this company?______________________________________
If so where? ____
What are your family Physicians Names and Address? ____________________________________

I, _________________________, authorize my employer to request and obtain all records regarding any industrial accident/injury or occupational disease involving myself and this employer. This is to include doctor's reports, follow-up reports, nurse's notes, medical bills, test results, etc.

A facsimile or photo copy of this authorization shall be considered as effective and valid as the original. This release shall remain in effect until specifically rescinded by me.

____________________________ ______________________
Employee Signature Date