ACCIDENT INJURY REPORT

EMPLOYEES MUST IMMEDIATELY REPORT ACCIDENTS/INJURIES TO MANAGEMENT

Employee full name: _____ Phone number: _____

Full address: _____

Date of birth: _____ Work location: _____Shift worked at time of accident/injury: _____

Date of accident/injury: _____ Time: _____ Staff present/witnessed: _____

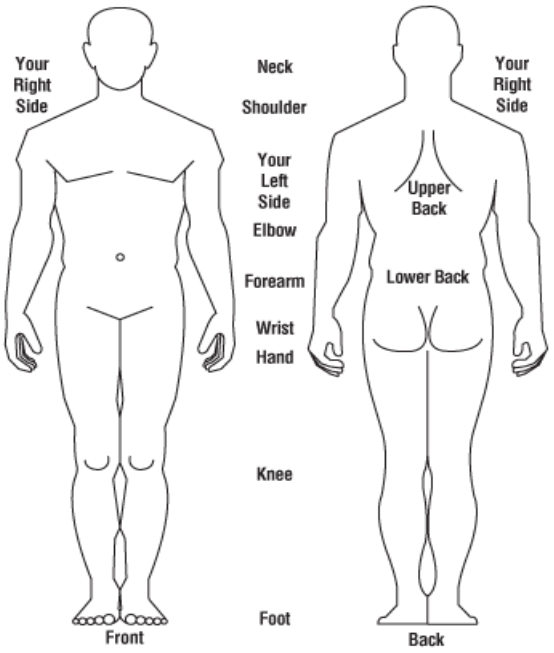
Do you need medical attention? (Initial your choice) ___YES___NO *Call 911 if injury is life threatening*. For all other accident/injury, contact Management ***immediately*** to report. **Management will instruct employee to call TeleCompCare @ 1-866-323-4227 (LADD account #20041) and select option #1 to determine/arrange medical attention**. If you do not contact Management and seek medical attention *without approval*, it is at your own risk as treatment costs may not be covered under workers compensation. Drug testing may be required and completed at the clinic based on circumstances. Management reserves the right to drug test at any time per our Drug Policy. For more information about accident/injuries, view the LADD Accident/Injury Policy located in the LADD Directory on the website, www.laddinc.net, Employee Login/LADD Directory.

If this is an exposure incident, (blood, saliva, urine, feces, etc.), the employee and Manager or Supervisor must complete the Accident/Injury Occupational Occurrence Report located in the Staff Log.

Describe what type of injury was sustained: _____

How was this injury sustained? _____

What part of the body was injured? Please mark on bodies below:



Cause: (check one or more)

__ Slip and/or Fall

__ Struck/Bit by a Person Supported

__Lifting or Moving

__Needle Puncture

__Object in Eye

__Struck by Something/Someone Other Than a Person

__Vehicle Accident

__Other_____

Type of Injury: (check one or more)

__ Scrape/Bruise

__ Sprain/Strain

__Puncture Wound

__Cut/Laceration

__Head Injury

__Bite

__Chemical Burn/Difficulty Breathing

__Other_____

TREATMENT INFORMATION for MEDICAL PERSONNEL:

This person is an employee of LADD, 300 Whitney Street, Dowagiac, MI 49047. Employee is covered under workers compensation, Accident Fund account #6032875, 866-206-5851. Send all treatment results and billing to fax # 248-565-0303. All questions go to Lynne Corak, Director of Human Resources, 269-783-4116 (office), or 269-340-9250 (cell).

Employee signature: _____ Date: _____

LADD
WE MAKE THE DIFFERENCE
300 WHITNEY STREET
DOWAGIAC MI 49047
269-782-0654

Employee full name: _____

Management to fill out information below and send with Accident/Injury Report (page 1) to:

Director of Human Resources: 269-783-4116
Scan and email to; humanresources@laddinc.net *OR* Fax; 248-565-0303

Date last worked: _____

Did the staff seek medical treatment? ___Yes ___No

If answered yes above, enter checkmark next to the medical treatment:

___Minor medical treatment by employee
___Hospitalization for more than 24 hours
___Minor medical treatment by clinic/hospital
___Future medical/lost time anticipated
___Emergency care
___**Exposure Incident – If checking Exposure Incident (i.e., blood, saliva, urine, feces, etc.) the employee and Manager MUST complete the Accident/Injury Occupational Occurrence Report in addition to these forms.**

What date was the injury reported to Management? _____

Additional comments: _____

_____

_____

_____

_____
Management Name & Signature of Review and Completed Documentation