EST. 1836
MICHIGAN CITY
INDIANA

100 E. Michigan Blvd., Michigan City, IN 46360 Phone: 873-1427 ext. 2087 Fax: (219) 873-1552

Workers' Comp Instructions

Complete an incident form **immediately** following the incident in the building or on the property.

The injured party should complete and sign the form and list any witnesses.

The form should be signed by the Supervisor and sent to Human Resources by the Supervisor or secretary.

If there are witnesses, please have them complete the attached form.

If the injured staff person needs immediate care, they should be directed to go to **Franciscan WorkingWell located at 4111 Franklin St, Michigan City, IN 46360 (219) 879-5400** unless they are taken away in an ambulance (For life threatening events).

This is an authorized facility that provides care at no cost to the injured employee.

Any delays in forwarding the forms can result in the injured party being charged and responsible for the services.

If you have questions or concerns, please contact Shante Ivy at (219) 873-1427, ext. 2014 or email sivy@emichigancity.com

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FIRST REPORT OF INJURY/INCIDENT WORKERS' COMPENSATION

Name: _____ Employee # _____

Home Address:_____

City, State, Zip Code_____

Phone #_____Date of Birth_____Date of Hire_____

Department: _____

Date of Injury: _____ Employer Notified Date: _____

Time Employee began work: _____ Time of Incident:_____

Name of Witness(es):

Name: _____Phone: _____

Where did the accident occur? Please list the location and specific area at the location

_____

What was the employee doing at the time of the incident? Describe the activity, as well as the tools, equipment or material the employee was using. **Be specific**. (ex. Standing on a step stool getting a book off the shelf) _____

_____

_____

What happened? Describe how the injury occurred. (ex. When the step ladder tipped over, I fell on the floor)

_____

_____

What was the injury or illness? Describe the part of the body affected (ex. include whether left or right, front or back, etc.) and how it was affected. Be specific; do not use "hurt," "pain," or "sore". Identify specific injury, such as strained back, bruised knee, chemical burn) _____

_____

_____

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What object or substance directly harmed the employee? (ex. Concrete floor, chlorine, if not applicable leave blank)

_____

_____

Did the employee miss any work due to the accident? If so, give first date of absence following the date of accident. _____

Did the employee seek medical attention? _____

Was an ambulance called? ____ Yes _____ No Was employee treated in emergency room? ___ Yes ____ No

Name of hospital or emergency room (if applicable)

_____

Employee Signature _____

Supervisor Signature _____

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WITNESS STATEMENT (If necessary)

Location and Time of Accident: _____

Conditions of Location: _____

Your Name: _____

Relation to Employee: _____

Your Address: _____

City: _____ State: _____ Zip: _____

Your telephone Number: Home: _____ Cell: _____

Please describe the incident you witnessed below:

Narrative

_____

_____

_____

_____

Printed Name: _____

Signature: _____

Date: _____