EASTERN
MICHIGAN UNIVERSITY

EMPLOYEE OCCUPATIONAL INJURY REPORT PACKET

Review entire packet with employee and note the following:

- **Employee and Supervisor**
  - Must complete injury report.
  - All fields must be completed and signatures included.
  - **Supervisor** must then email documents to injury_report@emich.edu or fax to 734-487-7590.
- **Supervisor** must complete the **Authorization for Treatment** form (Injury Report Packet - Page 8 of 9) for employee to provide to the designated clinic for medical treatment.
- **If after hours and treating at the SJMHS Emergency Department**
  - Employee must take the **Examining Physician's Statement of Physical Capacities** form (Injury Report Packet - Page 9 of 9) for the treating physician to complete.
- **After treatment**
  - This completed form must be emailed or faxed to HR Benefits.
  - Email: injury_report@emich.edu
  - Fax: 734-487-7590
- **In the case of an emergency**
  - Supervisor should contact the HR Benefits Office at 734-487-3195 or via email to injury_report@emich.edu as soon as possible after the employee has been transported for medical treatment to provide information on the injury.
  - If after hours, Supervisor should call DPS at 734-487-1222.

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Human Resources – Benefits (Total Rewards) – 140 McKenny
injury_report@emich.edu ~ Fax 734-487-7590

Procedures for Occupational Injury or Illness

Please review this entire packet and complete all forms in their entirety to avoid delay of your claim.

The following situations *must* be reported immediately to HR Benefits, Environmental Health and Safety or DPS if after hours, weekend or holiday:

- **Any accident resulting in a fatality;**
- **Any hospitalization (being admitted) of 1 or more employee(s) suffering injury from the same accident/incident associated with their employment;**
- **Any hospitalization (being admitted) of 1 or more employee(s) suffering illness from exposure to the same health hazard associated with their employment**

HR Benefits: 734-487-3195 – email: injury_report@emich.edu
Environmental Health & Safety – 734-487-0794
DPS: 734-487-1222

For all other work-related injuries/illnesses:

- Injured employee must notify a supervisor after a work-related injury or illness occurs.
- Provide employee with the Report of Employee Occupational Injury packet by going online to the HR website to print as needed. Review the instructions and provide employee with applicable forms required for medical treatment. Complete the injury report and email to injury_report@emich.edu or fax to 734-487-7590. Failure to submit this report will delay the claim, or cause it to be denied.
- It is the employee's responsibility to contact a Supervisor, and/or HR Benefits immediately after treatment for the following:
    1. If the injury results in missed work days;
    2. To provide medical documentation from treatment and/or confirm that HR Benefits has received the documentation from the Provider directly.

The Workers' Compensation Act allows an employer to direct care for its injured employees for 28 days.

Except in the case of a life-threatening emergency, employees must seek medical treatment at one of the clinics designated by EMU.

Failure to seek treatment at one of these clinics may cause claims to be delayed or denied.

Employee claims will be administered by The ASU Group. The injured employee will receive contact information for an adjuster once their claim is filed.

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injury_report@emich.edu - Fax: 734-487-7590

Employees MUST seek medical treatment at one of the following clinics.

The Workers' Compensation Act allows an employer to direct care for its injured employees for 28 days.

Failure to seek treatment at an EMU designated clinic can delay and/or cause your claim to be denied

Currently, IHA Campus Medical is not a designated clinic

MI Urgent Care & Occupational Health **Ann Arbor** 3280 Washtenaw Avenue Ann Arbor, MI 48104 734-389-2000 **Check website for hours and to "check- in" online:** **https://nextcare.com/locations/mi/ann-arbor/**	**Michigan Urgent Care & Occupational Health** **Dundee** 100 Powell Drive, Suite 8 Dundee, MI 48131 734-823-5900 **Check website for hours and to "check- in" online:** **https://nextcare.com/locations/mi/dundee/**

Michigan Urgent Care & Occupational Health
Brighton
2300 Genoa Business Park Dr. Ste.120 Brighton, MI 48114
810-844-0400

Check website for hours and to "check- in" online:

https://nextcare.com/locations/mi/brighton/

AFTER HOURS ONLY:
St. Joseph Mercy Hospital (SJMHS)
5301 McAuley Drive
Ypsilanti, MI

Employee must take the completed Authorization for treatment form

If you seek after-hours treatment at this location, you are required to forward documentation from the visit to the EMU WC Office by the next business day. Any follow up treatment needed will be directed by The ASU Group, EMU's third-party administrator for WC claims. **Failure to provide documentation and/or seek follow up treatment as directed can delay your claim or cause it to be denied.**

EASTERN MICHIGAN UNIVERSITY

EMPLOYEE OCCUPATIONAL INJURY REPORT

EMPLOYEE SECTION PAGES 1-2. ***All fields must be completed to avoid delay in processing your claim.***

Employee *and* Supervisor sign on page 2.

If you will miss any work beyond the date of injury, it is your responsibility to contact your Supervisor, and the HR Benefits Office.

Employee Information - ALL FIELDS MUST BE COMPLETED – PLEASE PRINT LEGIBLY OR TYPE:

Your Social Security # is required for all claims. For privacy, this information will be extracted from EMU's file.

Name:_____ EID #: _____
Last First Middle

Home Address: _____
Number Street (Apt #) City State Zip Code

Phone #:_____ Birthdate: _____
Home Work (mm/dd/yy)

Gender: ☐ Male ☐ Female ☐ Not specified Marital Status: _____

Date of hire by the University:_____ Do you claim on-the-job injury? ☐ **Yes** ☐ **No**

Retirement Plan: ☐ **MPSERS** ☐ **TIAA –CREF** ☐ **NONE**

Injury/Illness Information - ALL FIELDS MUST BE COMPLETED – PLEASE PRINT LEGIBLY OR TYPE:

Date of Injury/Illness: (mm/dd/yy) _____

Time shift began on date of injury/illness:_____am/pm

Time injury/illness occurred:_____am/pm

Address and/or location injury/illness occurred – give specific details such as building name, floor or office number, location of stairwell, etc.: _____

_____

List any EMU witnesses to the accident (first and last names): _____

_____

_____

What were you doing ***just before*** the injury/illness occurred? Provide specific details:

_____

_____

_____

_____

How did injury/illness happen? Provide specific details. _____

_____

_____

_____

_____

What object or substance directly harmed you? Provide specific details. _____

_____

Injury Information - ALL FIELDS MUST BE COMPLETED – PLEASE PRINT LEGIBLY OR TYPE:

What body part(s) is affected? Provide specific details. _____

_____

Nature of injury - Provide specific details such as pain, bruising, laceration, etc. _____

_____

Did you seek medical attention? ☐ **Yes** ☐ **No** If yes, where: _____

If yes, list date and time of medical treatment: _____

List date and time injury/illness was reported to Supervisor: _____

If not reported on the date of injury, explain the delay: _____

_____

Signature Information:

I, the undersigned employee, acknowledge that the above statement is true, and the accident and injury occurred within the course of my employment at Eastern Michigan University.

Providing false information is cause for discipline, up to and including dismissal from employment. It may also be cause for criminal prosecution.

Print Employee Name: _____

Signature of Employee: _____ Date: _____

Employee email address: _____

Print Supervisor Name: _____

Signature of Supervisor: _____ Date: _____

Supervisor signature signifies receipt of employee's report but does not acknowledge content as fact.

EASTERN MICHIGAN UNIVERSITY

Report of Employee Occupational Injury – SUPERVISOR SECTION

In the case of a life-threatening emergency, employee should seek medical treatment at the nearest medical facility.

Employee completes and signs pages 1-2, prior to Supervisor signature on page 2.
Supervisor signs page 2, and completes/signs pages 3-4, prior to providing the entire report to HR Benefits.

Please type or print legibly. *All fields must be completed*.

If employee is seeking medical treatment, provide employee with a completed Authorization for Treatment form, and email a copy with this report to injury_report@emich.edu or fax to 734-487-7590

Advise employee, if they will miss any work beyond the date of injury, it is their responsibility to contact you, and the HR Benefits Office with this information.

ALL FIELDS MUST BE COMPLETED – PLEASE PRINT LEGIBLY OR TYPE

Employee Information:

Employee's Name: _____
Last First Middle

Employee's Classification and Grade: _____ Job Title: _____
(Example: FM-10) (Example: Groundskeeper)

Type of Employee: ☐ Full-time ☐ Part-time ☐ Student ☐ Other

Fund: ☐ General ☐ Auxiliary ☐ Other

Department: _____

Date of Injury/Illness: _____ Time injury/illness occurred: _____ a.m. / p.m

Date and time reported to Supervisor: _____

Employee's regular work schedule: ☐ S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sa

Employee's regular work schedule shift start to end time: _____

Medical Treatment:

Where did employee seek medical treatment? _____

Lost time information:

Did employee lose full days away from work due to alleged work related injury? ☐ **Yes** ☐ **No**

If yes, list all days missed of work: _____

Safety Information:

Does employee's statement coincide with your findings? ☐ Yes ☐ No

If no, state any inconsistencies you found while investigating employee's statement of what happened (including speaking to any witnesses' employee has listed:

_____

_____

Did the injury/illness result from a violation of a rule that is clearly announced and regularly enforced?

☐ Yes ☐ No If yes, please describe: _____

_____

Do you dispute this injury? ☐ Yes ☐ No If yes, please describe: _____

_____

Please provide any additional information here, or contact the WC Office: _____

_____

_____

Supervisor Information:

Print Name of Supervisor: _____

Signature of Supervisor: _____ Date: _____

Supervisor's Phone #: _____

Supervisor's email address: _____

Email *completed* report to:
injury_report@emich.edu or fax to 734-487-7590

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MICHIGAN UNIVERSITY

AUTHORIZATION FOR TREATMENT

(Work- related injury)

This form authorizes treatment for a work related injury at the EMU designated clinics listed below ***only***:

MICHIGAN URGENT CARE & OCCUPATIONAL HEALTH:
Ann Arbor – 3280 Washtenaw Avenue, Ann Arbor
Brighton – 2300 Genoa Business Park Drive Suite 120, Brighton
Dundee – 100 Powell Drive Suite 8, Dundee

AFTER HOURS ONLY:
St. Joseph Mercy Ann Arbor Hospital - 5301 McAuley Drive Ypsilanti, MI 48197

ATTN: Registration

Employer Name: **EASTERN MICHIGAN UNIVERSITY**

Employee Name: _____

Date of Injury: _____

Body part: _____

The above employee is authorized to receive treatment for the injury indicated above.

EMPLOYER AUTHORIZATION

Supervisor Printed Name: _____

Supervisor Signature: _____

Your signature indicates the employee is seeking medical treatment for a claimed work-related injury.

Supervisor Telephone:_____ Date: _____

PROVIDER: Please send medical reports and any accompanying documents immediately after treatment to: **Eastern Michigan University** **ATTN: HR Benefits** **injury_report@emich.edu** **Fax: 734-487-7590** **Telephone - 734-487-3195**	**PROVIDER:** Please send billing to: **The ASU Group** **1-800-968-3767** **Fax 866-747-0002** **2120 University Park Drive** **Okemos, MI 48805-0077**

For authorization of additional diagnostic testing/specialist referral, please contact ASU as follows:
Kim Lobdell – Sr Claims Examiner– 517-381-7507 ~ klobdell@asugroup.com

EXAMINING PHYSICIAN'S STATEMENT OF PHYSICAL CAPACITIES

EASTERN MICHIGAN UNIVERSITY

St. Joseph Mercy Hospital ER

EMPLOYER: Eastern Michigan University

Patient/Employee Name: _____

Date of Service: _____ **Time in:** _____ ☐ AM ☐ PM **Time out:** _____ ☐ AM ☐ PM

DIAGNOSIS:

Return for follow up on:

Referral Information:

Notes:

☐ Return to Regular Work on: _____

☐ Return to Restricted Work on: _____

☐ Unable to Work until: _____

Print Provider Name: _____

Provider Signature: _____

Patient Signature: _____

Patient/Employee returned to work with the following restrictions:

LIFTING RESTRICTIONS:

No lifting weight over_____lbs.

POSITION

☐ No lifting below knee or above shoulder level
☐ No lifting or carrying objects more than 12 inches away from torso

MOBILITY

☐ Sitting work only with leg elevated
☐ No climbing: ☐ stairs ☐ ladders ☐ poles
☐ Must use: ☐ crutches ☐ cane to walk
☐ Avoid walking on uneven surfaces
☐ Walking limited to_____hours/day
☐ Must wear support on ☐ L ☐ R ☐ Both ☐ ankle ☐ knee
☐ No squatting
☐ No kneeling
☐ Allow for periodic change of position
☐ Avoid awkward positions which require sustained bending, twisting or working in cramped spaces.
☐ Repetitive bending or stooping as tolerated
☐ Sit ☐ Stand as tolerated
☐ No driving any vehicles at work
☐ Safety sensitive medication prescribed
☐ Avoid awkward positions or extending arms
☐ No lifting above shoulder level
☐ No use of ☐ L ☐ R ☐ B ☐ arm(s) ☐ hand(s)
☐ Grip ☐ Lift with ☐ L ☐ R ☐ B hand(s) limited
☐ Must wear ☐ sling ☐ splint
☐ No work more than 18 inches from body
☐ No use of power tools which exert a torque force (drills, power screwdrivers, etc.)
☐ Other:

LACERATIONS, ABRASIONS, BURNS

☐ With Sutures ☐ Without Sutures
☐ Cover with dressing and keep dry
☐ Change dressing if wet
☐ No contact of dressing by solvents, oils, grease, detergents
☐ No work around open flames or high heat areas (stoves, furnaces, ovens, heaters)

IHA/SJMHS: Please give completed copy to employee, and send copy to EMU HR Benefits immediately following treatment. Fax: 734-487-7590 or email to injury_report@emich.edu