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## **On the Job Injuries Workers Compensation Procedures**

### **Introduction**

In any industry, employees must report any on-the job injuries in a timely manner to ensure prompt medical attention, continued on-going care, and a responsive worker compensation process. As the healthcare environment poses a higher risk for some occupational exposures (i.e., bloodborne pathogens, back injuries), a timely report of injury can prevent future health concerns relative to the injury/exposure.

### **How can occupational exposures be prevented?**

Some of the more common on-the-job injuries among healthcare workers include back injuries, slips/falls, and needlesticks. Many of these risks can be reduced and eliminated with safer techniques, increased education and awareness, as well as improved devices and protective equipment. HCS works with our client facilities to ensure that all employees have information and resources readily available to protect their own safety, as well as that of their patients. While at an assignment, employees should follow the policies and procedures of HCS and the client facility for reporting on-the-job injuries.

### **What should I do if I am injured while at work?**

If you are injured on the job, you should:

- First, seek medical care immediately, if needed. Advise the healthcare provider that the injury was work-related.
- Notify your assignment unit supervisor as soon as possible.
- The supervisor, employee, or other facility personnel should contact HCS at 770-991-2515 to report the injury within 24 hours of the incident. Failure to notify HCS of an injury may result in your claim being disallowed by the Workers Compensation Board.
- The employee, supervisor, and any witnesses to the incident/injury should complete the appropriate forms and fax them to the attention of HCS Workers' Compensation Liaison at 770-991-1557.

Upon receipt of the documentation an HCS representative will follow up with the employee, supervisor, and witnesses as needed to ensure that the employee is taken care of and that all documentation is complete so that a report can be filed with our workers' compensation provider.

### **What should I do if I have a needlestick or other potential exposure to bloodborne pathogens while at work?**

Follow the procedure as outlined above. Report the exposure to the department (e.g., occupational health, infection control) responsible for managing exposures at your assigned facility and to the HCS workers' compensation liaison. Prompt reporting is essential because, in some cases, post exposure treatment may be recommended and it should be started as soon as possible. Also, any delay in reporting may affect the eligibility of a claim.

### **Where can I get copies of the forms needed for reporting an incident/injury?**

Copies of the Employee Report of Incident/Injury form, Supervisor Report of Incident/Injury form, and Statement of Witness to Incident/Injury form are available:

- Online at [www.healthcare-staffing.com](http://www.healthcare-staffing.com).
- By fax or email by contacting the corporate office via phone at 770-991-2515 or via email at [info@healthcare-staffing.com](mailto:info@healthcare-staffing.com)

### **How may I get more information?**

If you have further questions or need more information, contact the HCS workers' compensation liaison at 770-991-2515.



# Employee's Report of Incident/Injury

To be completed by Employee (PLEASE PRINT IN BLACK INK)

Employee Name: _____	Social Security#: _____
Home Address: _____	Birth Date: _____
City, State Zip: _____	Telephone #: _____

Date of incident/injury or onset of symptoms: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM

Describe what caused the injury/symptoms, what were you doing just before the incident, and what you did after the incident (if you need more space, include a separate sheet). Be specific - name any object or substances involved: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you report this incident to anyone?  Yes  No If not, why not? \_\_\_\_\_

If yes, to whom?: \_\_\_\_\_ Title/Position: \_\_\_\_\_ When?: \_\_\_\_\_

Did anyone else see what happened?  Yes  No If yes, whom? \_\_\_\_\_

What part(s) of your body was/were affected? (Be specific, for example, right elbow, left knee, right index finger, etc.): \_\_\_\_\_  
\_\_\_\_\_

What type of injury did you experience? (Be specific, for example, bruise, scrape, laceration, etc.): \_\_\_\_\_

Accident location (address, city & state). Give the specific location of the incident (Be specific, for example, basement, stairs, roof, etc.): \_\_\_\_\_  
\_\_\_\_\_

Was any first aid provided at the scene?  Yes  No If yes, describe: \_\_\_\_\_

Did you seek other medical treatment?  Yes  No When? \_\_\_\_\_ Where? \_\_\_\_\_

If treatment was not sought immediately, explain why: \_\_\_\_\_

Is this an aggravation of a previous injury/symptom?  Yes  No

If yes, when were you last treated for the previous injury?: \_\_\_\_\_ By whom? \_\_\_\_\_

Have you ever had a similar injury?  Yes  No If yes, describe: \_\_\_\_\_

**MEDICAL RELEASE**

**(Under current workers' compensation law, the employer is entitled to a signed medical release)**

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to truststaff and designated representatives. A copy of this form will serve as the original. Please keep in mind that any person who knowingly and with the intent to defraud or deceive the Bureau fo Workers' Compensation or any insurance carrier, files a statement containing false, incomplete or misleading information may be subject to criminal penalties.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_  
(please print)



# Supervisor's Report of Employee's Incident/Injury

To be completed by Supervisor (PLEASE PRINT IN BLACK INK)

Employee Name: _____	Social Security#: _____
Date of Injury: _____	Location: _____

Provide in detail the events that led up to this incident or injury and those immediately following: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What type of investigation was completed that supports or refutes the circumstances concerning this injury: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Were there any witnesses to this injury?  Yes  No (if yes, witness statement must be included)

What action, if any, did you perform to assist the injured employee: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Did the injured worker complete his/her work shift?  Yes  No

Has there been any recent disciplinary action taken against this employee?  Yes  No

If yes, has documentation been provided?  Yes  No

Has the employee submitted medical documentation for the injury?  Yes  No

What date did the employee return to work?: \_\_\_\_\_

If not, what is the current estimated date of return?: \_\_\_\_\_

Can you provide modified or light duty should this be necessary?  Yes  No

Have you made contact with this employee since the incident?  Yes  No

With the information that you have, would you recommend the claim be accepted?  Yes  No

If no, why?: \_\_\_\_\_  
 \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(please print)

Title: \_\_\_\_\_

**Please attach completed incident reports, witness statements, and any accumulated medical bills and information. Additional comments may be noted on another sheet. Fax copies to the HCS Workers' Compensation Liaison at 770-991-1557 or mail to HealthCare Staffing, 5072 Clark Howell Highway, Atlanta, GA 30349. Questions? Call the HCS Workers' Compensation liaison at 770-991-2515.**



# Statement of Witness to Incident/Injury

To be completed by Employee (PLEASE PRINT IN BLACK INK)

Name of Employee Alleging incident: \_\_\_\_\_

Facility: \_\_\_\_\_

Department: \_\_\_\_\_

### WITNESS STATEMENT

Your name has been given to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your Name: \_\_\_\_\_ Your Title/Position: \_\_\_\_\_

Your Address: \_\_\_\_\_ Your Telephone #: \_\_\_\_\_

City, State Zip: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Did you observe an incident involving the above employee?  Yes  No

If not, how did you learn about the incident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you did observe an incident:

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_  AM  PM

Describe what you observed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Attach additional sheets if necessary

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_  
(please print)