Distribution	SUBJECT	Date
	EMPLOYEE INJURY REPORTS	09-01-2014

1. Any employee who is injured while at work or who has a work-related injury should **report the injury IMMEDIATELY to the Project Manager,** who will then report the injury to the Main Office (CM, CS or Personnel Department).

2. The **Project Manager** should immediately fax or email the Workers Compensation Reporting Form (P-11) to the main office. See attached example.

3. Upon receiving the first notification of injury, the Project Manager will be advised where to direct the injured employee for medical treatment.

   For Non-Emergency Medical Care

   Do not send the employee for medical treatment without first contacting the main office to report the injury and to receive the instruction for directing the employee to an **authorized provider.**

   For Emergency Medical Care

   The Project Manager should **immediately** have the employee proceed to the **nearest medical facility**. The Project Manager should then contact the main office to report the incident and to obtain instructions.

EXAMPLE

Workers Compensation Reporting Form

Company: **Flynn Management Corp., 516 Lakeview Road, Unit 8, Clearwater, FL 33756 727-449-1182**

Location Codes

Date of loss: _____

Account:

State: where injury occurred FL

Employee Name: WALTER JONES

Address: 2556 MAIN ST
OCALA, FL 34479

SSN: 123-45-6789

Phone: 352-555-4665 Date of Birth: 8-1-53 (Male)/Female

Regular position: MAINTENANCE Property: HAPPY TRAILS

Was employee performing regular duties of the position: YES

Job class code: 8810 clerical, 9012FL, 9012 GA - managers, (9015FL), 9015GA-maintenance

Was employee injured while on the job: YES

Language spoken by employee: ENGLISH

Marital Status MARRIED

Number of dependents: 0 Number of dependents under 18 yrs.: 0

Is the employee an owner, partner or officer of the company: NO

State in which employee was hired: FL

Does employee require ADA accommodations: NO

Employment status: (full-time) or part-time

Hire date with company: 2-4-2009

Hire date in current position: 2-4-2009

Does employee have group health insurance: YES

Number of hours scheduled per day: 8 number of days per week: 4

Wage information: 15.00 hourly _____ monthly

Was the employee paid for the full day of the injury: YES

Accident Information:

Date and time of accident: 8-25-14 11:00 Date and time reported to employer: 8-25-14 12:00

Who received report: IMA D. MANAGER

Shift hours: _____

Address where accident occurred: HAPPY TRAILS

Is this employer's premises: YES

EXAMPLE

Workers Compensation Reporting Form

Full description of accident: (Include part of body injured: left index finger, right knee, etc.)
FELL DOWN STAIRS - SPRAINED LEFT ANKLE
WAS CARRYING LIGHT FIXTURES TO APT. 614

Is the accident/incident questionable to employer: NO
Was employee permanently disabled as a result of accident/incident: NO
Does the employer supect drug and/or alcohol use at the time of the accident/incident: NO
Date of death (if fatality):
Number of days employee is expected to miss: ?
Last date worked and time employee left work: 8-25-14 12:15
First day missed: 8-26-14
Will the employees salary continue: **only to the extent of sick/vacation days available**
Does the employee have a previous claim: NO

Was any safety equipment provided: NO was it used
Was an unsafe act being performed: NO
If yes, describe:

Was a third party responsible for the accident/incident: NO
If so, please provide name, address and phone number:

Was accident/incident witnessed: NO
If so, please provide name, address and phone number:

Provider:
Was first aid given on site: NO
If yes, what treatment was received:

Did employee go to a doctor, hospital or clinic: YES
If so, please provide name, address and phone number: MEMORIAL MEDICAL CENTER
OCALA, FL 352-789-8300

Was employee hospitalized: NO if yes, date
Was employee treated as an outpatient, receive emergency treatment or ambulance service: YES
Claim # Office
Prescriptions:
Name of person submitting report: (Clearwater)
Name: IMA D. MANAGER Title: MANAGER Phone: 352-456-8765