

**To:** All Districts  
**From:** Edustaff HR Department  
**Re:** Workers Comp Procedure for all Edustaff Employees

There are two forms an Edustaff employee needs if they are injured. The forms and procedure are explained below.

**First Report of Injury:** This form is two pages and we need both pages completed. It is vital that this form is filled out completely by both the school/location and the employee and then sent to Edustaff HR (either to [humanresources@Edustaff.org](mailto:humanresources@Edustaff.org) or fax to 877-974-6339). This form allows us to start a claim with our worker's comp carrier, if treatment was sought. If there is not any treatment sought, we still need the form as we track all injuries.

**Authorization to Treat:** The employee will need to take this form with them to the medical facility if they seek treatment after an injury has occurred. This form has our phone number on it as well as the basic info of our worker's comp carrier for billing/contact purposes. When this form is presented to the place of treatment they know to set it up as a work comp billing claim. We do not need this form sent to us at all, and if no treatment is being sought, the employee does not need this form either.

**Where to treat:** Please send our employees to the same medical facility as you send your employees. Usually that is a Concentra or occupational health type of facility. Urgent Care is also an option if you don't have occupational health locations near you. They should not go to their own personal doctor, chiro, nor the emergency room unless, of course, the injury dictates an ER visit.

**Notification:** We do not need to be notified immediately by phone from the employee or school location, as long as the first report of injury is filled out as completely as possible and sent to us as soon as possible. Please forward all medical bills, work notes, and any other medical paperwork to us when received.

If you have any questions on this procedure, please feel free to contact  
Jackie Wierenga at 877-974-6338 ext. 145.



**FIRST REPORT OF INJURY**

Date of Report: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date Notified Employer: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Injury: \_\_\_\_:\_\_\_\_ AM/PM (circle one)

**Edustaff Employee Information:**

Employee Name (Last, First, Middle): \_\_\_\_\_

SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M/F (circle one)

Address (Number & Street): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Hire Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

**Injury Report Information:**

Job Location: \_\_\_\_\_

DISTRICT: \_\_\_\_\_

Start Time: \_\_\_\_:\_\_\_\_ AM/PM (circle one) End Time: \_\_\_\_:\_\_\_\_ AM/PM (circle one)

Address (Number & Street): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Witness to Injury: \_\_\_\_\_ Witness Phone Number(s): \_\_\_\_-\_\_\_\_-\_\_\_\_

Explain How Injury Occurred: \_\_\_\_\_

\_\_\_\_\_

Nature of Injury: \_\_\_\_\_



Part of the body directly affected by the injury: \_\_\_\_\_

Last Day Worked: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Employee Returned: \_\_\_\_/\_\_\_\_/\_\_\_\_

Was the injury fatal? Yes/No (circle one) If yes, date of fatality: \_\_\_\_/\_\_\_\_/\_\_\_\_

Did employee seek medical treatment? Yes/No (circle one)

If yes, date of treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of treatment facility: \_\_\_\_\_

Address (Number & Street): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Restrictions: \_\_\_\_\_  
\_\_\_\_\_

Expected return to work date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**District Information:**

Building Supervisor: \_\_\_\_\_  
(printed name and signature)

Phone Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

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

Feedback: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please return via email to Edustaff HR at [humanresources@Edustaff.org](mailto:humanresources@Edustaff.org) or via fax to 877-974-6339.  
Thanks!

## AUTHORIZATION FOR TREATMENT Workers Compensation

This form authorizes a health care provider to treat the following EDUStaff Employee:

for a work related injury that occurred on \_\_\_\_\_

at \_\_\_\_\_.

### Send all billing information to:

Accident Fund  
PO Box 40790  
Lansing, MI 48901

EDUStaff, LLC Workers Compensation Insurance

Policy Carrier: Accident Fund  
Policy Number: WCV6121051