Corporate Solutions
The Human Resource Solution

Accident Reporting Packet

Employee/ First Name: _____ Last Name: _____

SSN: _____ Position: _____

Date of Hire: _____

When an accident occurs, no matter how minor, please call Corporate Solutions 1-888-785-4018 immediately and report the incident. If the injury occurs in the evening or weekend/holiday, you will be prompted by the message machine with an emergency number. You will then be told where to take the employee. If the injury is life threatening, please take the employee to the nearest hospital and then report the incident. Any injury requires the employee to take a drug test. Make sure that Corporate Solutions receives the required incident reports within 24 hours.

Checklist

I. Accident Reporting Packet

1. Corporate Solutions First Report of Injury Yes ___ No ___
2. Corporate Solutions Supervisor Accident Report Yes ___ No ___
3. Corporate Solutions Employee Accident Report Yes ___ No ___
4. Corporate Solutions Witness Accident Report Yes ___ No ___
5. Corporate Solutions Consent for Drug/Alcohol Screen Testing Yes ___ No ___
   * All employees must be drug screened immediately after the accident.
6. Corporate Solutions Employee Voluntary Refusal to see a Doctor Yes ___ No ___
   * Only if employee feels he/she does not need to see a doctor
7. Corporate Solutions Authorization for Release of Medical Information Yes ___ No ___

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☐ M ☐

3. Social Security Number - -

4. Home Phone ( )

5. Date of Birth (m-d-y) - -

6. Does the Employee Speak English? If No, Specify Language
YES ☐ NO ☐

7. Race White ☐ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status
Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) - -

16. Time of Injury : am ☐ pm ☐

17. Date Lost Time Began (m-d-y) - -

18. Nature of Injury*

19. Part of Body Injured or Exposed*

20. How and Why Injury/Illness Occurred*

21. Was employee doing his regular job? YES ☐ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

Street or P.O. Box County

City State Zip Code

24. Cause of Injury(fall, tool, machine, etc.)*

25. List Witnesses

26. Return to work date/or expected (m-d-y) - -

27. Did employee die? YES ☐ NO ☐

28. Supervisor's Name

29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -

31. Was employee hired or recruited in Texas? YES ☐ NO ☐

32. Length of Service in Current Position Months _____ Years

33. Length of Service in Occupation Months _____ Years

34. Employee Payroll Classification Code

35. Occupation of Injured Worker

36. Rate of Pay at this Job $_____Hourly $_____Weekly

37. Full Work Week is: _____Hours _____Days

38. Last Paycheck was: $_____for ____Hours or _____Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form

41. Name of Business

42. Business Mailing Address and Telephone Number
Street or P.O. Box Telephone ( )

City State Zip Code

43. Business Location (If different from mailing address)
Number and Street

City State Zip Code

44. Federal Tax Identification Number

45. Primary North American Industry Classification System Code:(6 digit)

46. Specific NAICS Code (6 digit)

47. Texas Comptroller Taxpayer No.

48. Workers' Compensation Insurance Company

49. Policy Number

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

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Supervisor Accident Report

Report due within 24 hours of accident

Client Company _____

Employee/First Name: _____ Last Name: _____

Date of Report _____ Date of Accident/Time _____

Location of Accident _____

_____
Nature of Injuries

_____
Cause of Accident

_____
Were safety devices/equipment used?

_____
Was the employee following proper procedures, directions or training as illustrated in the Safety Manual when the accident occurred?

If employee left work, time of leaving _____

Did employee return to work? Yes (_____) Time_____ No (_____)

_____
Name of Physician

_____
If hospitalized, name of hospital

_____
Is there any information regarding the accident that the employer should know?

_____
What actions were undertaken to avoid such future accidents?

Comments:_____

_____

_____

Supervisor Name (Print) _____ Signature _____

_____

(FOR OFFICE USE ONLY)

_____

_____

_____

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Employee Accident Report

Client Company: _____

Employee/ First Name: _____ Last Name:_____

Date of Report _____ Date of Accident/Time _____

Location of Accident _____

Describe details of accident (How, what, where, why) _____

_____

Type of Injury (Cut, bruise, sprain, etc.) _____

_____

Body Location (hand, head, back, etc.) _____

_____

Was special protective equipment provided or required (goggles, special shoes, helmets, etc.)

Yes _____ No _____ If yes, what kind? _____

Was it readily available? Yes _____ No _____ If no, explain. _____

_____

Was such equipment being used or worn at the time of the accident? Yes _____ No _____

If no, why not? _____

Were there any witnesses to the accident? Yes _____ No _____ If yes, please list names.

Witness 1 _____ Witness 2 _____

Witness 3 _____ Witness 4_____

I, _____ (Employee), the undersigned, certify that the above is a true and correct statement of fact, and that I made such statements of my own free will. I understand that any payments to me or anyone else for expenses in connection with my accident and resulting injury is not an admission of liability on the part of **CORPORATE SOLUTIONS** I authorize full access to copies of medical records, radiology reports, drug/alcohol screenings, and documents of any kind relating to my past or present injury/illness to **CORPORATE SOLUTIONS.** I hereby agree to release this information and hold all such medical providers harmless from the release of this information as set forth in this authorization.

_____ _____

Employee Signature Witnessed by (Signature)

_____ _____

Employee Printed Name Witnessed by (Printed Name)

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Witness Accident Report

Client Company: _____ Date: _____

Witness Name: _____ Relation to Injured: _____

Date of Accident/Time: _____ Date of Report: _____

Location of Accident: _____

Describe in detail what you witnessed of the accident in your own words (How, what, where, why, etc.)
If you need additional space for writing/diagrams, etc., please attach additional sheets to report.

_____
_____
_____
_____
_____
_____
_____

_____
_____
_____
_____
_____

I, _____ (Witness), the undersigned, certify that the above is a true and correct statement of fact, and that I made such statements of my own free will.

_____ _____
Witness Signature / Date Phone Number

Check here if this form was prepared/ translated _____

_____ _____
Preparer/ Translator Signature / Date Preparer/ Translator Printed Name

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Consent For Drug/ Alcohol Screen Testing

I _____**(Name of Applicant)**, have been fully informed by my potential employer of the reason for this test for drug and/or alcohol. I understand what I am being tested for, the procedure involved, and do hereby freely give my consent. In addition, I understand that the results of this test will be forwarded to Corporate Solutions and become part of my record.

If this test result is positive, and for this reason if my pre-employment or my current employment status is affected, I understand that I will be given the opportunity to explain the results of this test.

I hereby authorize these test results to be released to Corporate Solutions. and **(Client Company)**

_____due to their co-employment agreement.

_____ _____
Applicant Signature Date

_____ _____
Witness Signature Date

(FOR OFFICE USE ONLY)

Reason for testing *(Circle One)*

Pre-Employment
Random
Reasonable Cause
Accident Investigation
Routine

Testing Appointment (Date/Time)_____
Clinic Name _____
Address _____
City _____State _____
Phone # _____ Fax# _____
Results Expected back _____

Service To Be Performed *(Circle One)*

DOT Physical DOT DRUG Screen Breath Alcohol
NON-DOT Physical NON-DOT Drug Screen Other _____

Comments:

_____
_____
_____
_____
_____

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Employee Voluntary Refusal To See A Doctor

Attn: _____ Date: _____

Fax: _____ Client Co: _____

Employee/First Name: _____ Last Name: _____

Date of Injury:_____

Hereby states that he/she chooses not to visit a doctor with regard to this work related accident.

_____ _____

Employee Signature Date Witness Signature Date

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

Please call (956) 928-0688/888-785-4018 if any problems occur in transmission. For your convenience in transmitting to us, our fax # is (956) 928-0963/888-869-9176. This facsimile may contain confidential information only intended for the person named above. If you received this facsimile in error, please contact (956) 928-0688/888-785-4018 immediately. Thank You.

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Authorization for Release of Medical Information

Patient: _____

To Whom It May Concern:

You are hereby expressly authorized to release and furnish to Corporate Solutions and/or any associate, assistant representative, agent, or employee thereof, any and all desired information (including, but not limited to, office records, medical reports, memos, hospital records, laboratory reports, including results of any and all tests including alcohol and/or drug tests, X-rays, X-ray reports, including copies thereof) pertaining to the physical and/or mental condition which is the basis of my worker's compensation claim. This includes not only current and/or future information, but also all past medical information.

PRINT/ FIRST NAME: _____ LAST NAME: _____

Photo static copies of this signed authorization will be considered as valid as the original.

This is not a release of claims for damages.

DATED: _____ SIGNED: _____

PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT SO THAT WE MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.

Thank you,

CSI