



Policy for Reporting Work Related Injuries

When an injury occurs on your jobsite notify DecisionHR immediately at 1-888-828-5511 ext. 5228 to report the incident. Then complete the injury report and fax to Elle McAree at DHR: (727) 388-1136 or fax toll free to (888) 802-7555.

- **Information needed for reporting an injury:**
 1. Employee name
 2. Date of injury
 3. How injury occurred and specific body part injured.
DHR will select a treatment facility for the employee.

- **If an injury is life threatening:**
 - 1st - Seek the nearest hospital or dial 911
 - 2nd - Notify DHR immediately: (727) 456-5002 or (888) 828-5511.

**After Hours* If an injury occurs after hours, leave details of the injury, your company name, contact person and phone number on the DHR answering service. Then proceed with necessary medical care and fax the injury report as mentioned above.*

- **Post Injury Drug testing:**
 1. Mandatory for all injuries
 2. Provide injured employee with a DHR Drug Test Chain of Custody
 3. Must be completed within 24 hours of injury.

Important: All injuries are to be reported within 24 hours of occurrence. Failure to report timely may jeopardize employee benefits and subject employer to penalties by the Division of Workers' Compensation.



WITHIN 24 HOURS OF NOTICE FROM INJURED EMPLOYEE:

COMPLETE THIS FORM *and*

Call: Elle McAree at (888) 828-5511 ext. 5228 or (727) 456-5002

Fax: (727) 388-1136 or Email: emcaree@decisionhr.com

DecisionHR TeleClaim Workers' Compensation Questions

Client Company Name: _____

TeleClaim account number: _____

Date of Loss: _____ State in which loss occurred: _____

Employee Information

1. Employee's full name: _____

2. Employee's social security number: _____

Accident/Incident Information

1. Date and time of accident: _____

2. Date and time reported to employer: _____

3. Who was the accident reported to: _____

4. Employee supervisor: _____

5. Shift begin and end time: _____

6. Address where accident/incident occurred (street, city, state, zip code and county).

7. Is the above address the employer's premises? Yes No

8. Full description of accident/incident (include what employee was doing, work process, cause, injury and body part): _____

9. Is the accident/incident questionable to the employer? Yes No

10. Was employee permanently disabled as a result of the accident/incident? Yes No

11. Does the employer suspect drug and/or alcohol use at time of accident/incident? Yes No

12. Date of death (if accident resulted in a fatality): _____

13. Number of days employee is expected to miss (if applicable): _____

14. Last date worked and time employee left work: _____

15. First date missed: _____

16. Was the employee's salary continued? Yes No

17. Has employee returned to work? Yes No If yes, what date: _____

If no, is there an expected work return date? Yes No Date: _____

18. Does employee have a previous claim? Yes No; If yes, is the status Open Closed

Body part affected and date of loss: _____

Accident Investigation Information

- 1. Was any safety equipment provided? Yes No; if yes, was it used? Yes No
- 2. Was an unsafe act being performed: Yes No
If yes describe: _____
- 3. Was a machine part involved? Yes No
If yes describe part: _____
- 4. Was the machine part defective: Yes No
If yes, in what way? _____
- 5. Was a third party responsible for the accident/incident: Yes No
If yes, name, address and phone? Yes No; Third party name & address: _____
- 6. Was the accident/incident witnessed? Yes No; If yes, name, address and phone? Yes No
Witness name & address: _____
- 7. Name, address and phone of person to contact regarding additional loss information: _____

Provider Information

- 1. Was first aid given onsite? Yes No; If yes, what medical treatment was received? _____
- 2. Clinic/Doctor – Doctor name, specialty (i.e: fam prac, chiro, etc.) address, city, St, zip & phone: _____
- 3. Hospital name, address, city, St, zip & phone. _____
- 4. Was employee hospitalized? Yes No; If yes, on what date? _____
- 5. Was employee: treated-outpatient received for emergency treatment
 transported by ambulance
- 6. Name of person reporting this claim, including title and phone number: _____

Employee Signature

Date