# Workers Compensation Injury Checklist

**AL, AR, FL, IN, MI, NC, SC**

| **WHAT TO DO** | | |
|---|---|---|
| ☐ | Do they need emergency treatment? | ER will not be covered if not life threatening |
| ☐ | Can you administer minor first aid? | |
| ☐ | Incident report: EVERY FIELD MUST BE FILLED OUT | |
| | IF THEY ARE GOING TO THE DOCTOR:<br>☐ Employee Form<br>☐ Supervisor Form<br>☐ Witness(es) Form<br>☐ State First Report of Injury Form<br>If employee does not wish to be treated, complete the Frist Report of Injury, and make sure they sign the Refusal for Treatment Form<br>☐ Refusal of Medical Treatment | Get all details, WHEN, WHY, WHAT, HOW even if they refuse medical care.<br><br>They can change their mind later. If they refuse treatment, **they still need a drug screen immediately when they report incident.**<br><br>Take a picture of injury if appropriate |
| ☐ | **Treatment**: If the employee requests treatment, **direct them to your designated facility** for care AND give them the authorization for treatment and pharmacy form. | They must have a drug screen **immediately after reporting incident**<br><br>Injuries must be reported same day |
| ☐ | **Complete drug screen for ALL incidents reported** | |
| ☐ | Send completed forms to sreynolds@wisestaffinggroup.comm with a brief explanation in the email | |
| ☐ | Will the client allow the employee back for light duty? | |
| ☐ | Communicate all known follow up information to sreynolds@wisestaffinggroup.com | |

For any questions, please call:
Sherry Reynolds
662-608-5062 ex 1010 (office)
662-523-7890 (cell)

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2
Rev. 10/2012

**STATE OF ALABAMA**
**EMPLOYER'S FIRST REPORT OF INJURY**
**OR OCCUPATIONAL DISEASE**

Example Form

## CLAIM REFERENCE

| 1. Insured Report Number | 2. Filing Office Claim Number | 3. OSHA Log Case Number |
|---|---|---|
| Leave Blank | Leave Blank | Leave Blank |

## EMPLOYER

4. Employer Business Name
5. Physical Address 1: Labor Source
6. Physical Address 2: 432 Magazine Street
7. City: Tupelo 8. State: MS 9. Zip: 38804

ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS
10. Mailing Address 1: Labor Source
11. Mailing Address 2: 3305 A Bob Wallace Ave
12. City: Huntsville 13. State: AL 14. Zip: 35805

15. Federal ID Number: Leave Blank
16. U.C. Account Number: Leave Blank
17. NAICS: Leave Blank

## INSURER / FILING OFFICE

18. Insurer Name
19. Insurer Federal ID Number: Leave Blank 18-27 Blank
20. Type Insurer Ins Co ☐ Self-Insurer ☐ Group Fund ☐

21. Filing Office Name
22. Mailing Address 1
23. Mailing Address 2 or Telephone Number
24. City 25. State 26. Zip
27. Filing Office Federal ID Number

## EMPLOYEE / WAGES

28. First Name
29. Middle Name
30. Last Name
31 Last Name Suffix (ie. Jr., Sr., III)

COMPLETE 28-81

32. Employee ID Number
33. Type Employee ID Number
SSN ☐ Passport Number ☐ Green Card ☐
Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1
35. Mailing Address 2
36. City 37. State 38. Zip 39. Phone

40. Gender
Male ☐
Female ☐

41. Date of Birth
42.Nbr of Dependents

43. Marital Status
Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐

44. Date Hired

45. Occupation Description

46. Number of Days Worked Per Week

47. Wages $
48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐

49. Received Full Pay For Day of Injury? Yes ☐ No ☐
50. Did Salary Continue? Yes ☐ No ☐

## INJURY / TREATMENT

| 51. Date of Injury | 52. Time of Injury a.m. ☐ p.m. ☐ unk ☐ | 53. Time Employee Began Work a.m. ☐ p.m. ☐ | 54. Date Disability Began | 55. Date of Death |
|---|---|---|---|---|
| | | | | |

PLACE OF ACCIDENT, INJURY, OR EXPOSURE

56. Site Address: Vuteq, USA
57. City: 7036 Greenbrier Parkway 58. State 59. Zip: 35756
60. County: Madison

61. Injury Occurred on Employer's Premises?
Yes ☐ No ☐

62. Date Employer Notified

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. ( Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

**PROVIDE DESCRIPTION CODES** to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
**(FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC**

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

67. Initial Treatment
First Aid By Employer ☐
Emergency Room ☐
Hospitalized > 24 Hours ☐
No Medical Treatment ☐
Minor Clinic / Hospital ☐
Hospitalized Overnight ☐
Outpatient Treatment ☐

68. Name of Treatment Facility
69. Address
70. City 71. State 72. Zip

73. Name of Physician or Other Health Care Professional

74. Has Injured Returned to Work
Yes ☐ No ☐

If so, 75. Date
76. Time a.m. ☐ p.m. ☐

## OTHER

| 77. Date Prepared | 78. Preparer's First Name | 79. Last Name | 80. Title | 81. Preparer's Telephone Number |
|---|---|---|---|---|
| | | | | |

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## CLAIM REFERENCE

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|---|---|---|
| | | |

## EMPLOYER

| | |
|---|---|
| 4. Employer Business Name<br>5. Physical Address 1<br>6. Physical Address 2<br>7. City 8. State 9. Zip | ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS<br>10. Mailing Address 1<br>11. Mailing Address 2<br>12. City 13. State 14. Zip |

| 15. Federal ID Number | 16. U.C. Account Number | 17. NAICS |
|---|---|---|
| | | |

## INSURER / FILING OFFICE

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|---|---|
| 18. Insurer Name<br>19. Insurer Federal ID Number<br>20. Type Insurer Ins Co ☐ Self-Insurer ☐ Group Fund ☐ | 21. Filing Office Name<br>22. Mailing Address 1<br>23. Mailing Address 2 or Telephone Number<br>24. City 25. State 26. Zip<br>27. Filing Office Federal ID Number |

## EMPLOYEE / WAGES

| | |
|---|---|
| 28. First Name<br>29. Middle Name<br>30. Last Name<br>31 Last Name Suffix (ie. Jr., Sr., III) | 32. Employee ID Number<br>33. Type Employee ID Number<br>SSN ☐ Passport Number ☐ Green Card ☐<br>Employment Visa ☐ Assigned by Jurisdiction ☐ |

| | | |
|---|---|---|
| 34. Mailing Address 1<br>35. Mailing Address 2<br>36. City 37. State 38. Zip 39. Phone | 40. Gender<br>Male ☐<br>Female ☐ | 41. Date of Birth<br>42.Nbr of Dependents |

| | |
|---|---|
| 43. Marital Status<br>Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐ | 44. Date Hired |
| 45. Occupation Description | 46. Number of Days Worked Per Week |
| 47. Wages $<br>48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ | 49. Received Full Pay For Day of Injury? Yes ☐ No ☐<br>50. Did Salary Continue? Yes ☐ No ☐ |

## INJURY / TREATMENT

| 51. Date of Injury | 52. Time of Injury<br>a.m. ☐ p.m. ☐ unk ☐ | 53. Time Employee Began Work<br>a.m. ☐ p.m. ☐ | 54. Date Disability Began | 55. Date of Death |
|---|---|---|---|---|
| | | | | |

| | |
|---|---|
| PLACE OF ACCIDENT, INJURY, OR EXPOSURE<br>56. Site Address<br>57. City 58. State 59. Zip<br>60. County | 61. Injury Occurred on Employer's Premises?<br>Yes ☐ No ☐<br>62. Date Employer Notified |

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. ( Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

**PROVIDE DESCRIPTION CODES** to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
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64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

| | | |
|---|---|---|
| 67. Initial Treatment<br>First Aid By Employer ☐<br>Emergency Room ☐<br>Hospitalized > 24 Hours ☐ | No Medical Treatment ☐<br>Minor Clinic / Hospital ☐<br>Hospitalized Overnight ☐<br>Outpatient Treatment ☐ | 68. Name of Treatment Facility<br>69. Address<br>70. City 71. State 72. Zip |

| 73. Name of Physician or Other Health Care Professional | 74. Has Injured Returned to Work<br>Yes ☐ No ☐ | If so, 75. Date<br>76. Time a.m. ☐ p.m. ☐ |
|---|---|---|
| | | |

## OTHER

| 77. Date Prepared | 78. Preparer's First Name | 79. Last Name | 80. Title | 81. Preparer's Telephone Number |
|---|---|---|---|---|
| | | | | |


***Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐***

## Authorization of Treatment

Employer:_____
Employee Name:_____
Employee DOB:_____
Employee SSN:_____

Guarantor: 432 Magazine Street
Tupelo, MS 38802
662-680-5062

Protocol:

- Please submit all medical paperwork to fax# (662)841-9961
- Medical invoices should be mailed to **company checked above and guarantor address.**

Part of body affected for treatment: _____

Authorized by:_____

Phone:_____

Date:_____


# PHARMACY INFORMATION

Employee listed below is authorized to received medication that has been prescribed by their treating physician, for their alleged work-related injury.

***Select Company Working For: LABOR SOURCE ☐ ONESOURCE ☐***

Printed Employee Name: _____

SSN: _____ DOB: _____ Date of Injury: _____

Pharmacy: __WALGREENS_____

Health Lift Help Line: __(844) 328-2048_____

BIN: _020743_____ Member ID: Social Security Number___

Group: (Pharmacy Generated) Address of Work & Phone Number

Authorized By:_____

Phone Number: _____

Date: _____

**Employee is to give this complete authorization form to the pharmacy at the time they present them with their prescription that was given to them by the treating physician.**


***Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐***

**Read the Following Statement Before Signing this Form.**

By signing below, I certify that the information provided is true and correct to the best of my knowledge. I also certify that I understand that if I refuse medical treatment, services, and/or supplies provided by my Wise Staffing Group and its member companies (Wise Staffing Services, Inc., Labor Source, LLC., Onesource Staffing, LLC., and Resource Management Group, LLC.) or if I refuse employment suitable to any partial disability caused by the above injury, that this could lead to my termination and may jeopardize my insurance benefits.

Signature of Injured Employee: _____

**Medical Records Release**

I, _____ , authorize that my employer, anyone acting on their behalf including but not limited to, their insurance carrier, attorney or other representative, shall be permitted to examine and obtain copies of all hospital, medical, vocational, drug screen records, interview all doctors, rehabilitation professionals vendors regarding all matters relating to any issue relevant to my Workers' Compensation Claim.

A copy of this authorization is to be considered as an original for this purpose.

Signature of Injured Employee:_____ Today's Date:_____


**Modified Duty Form**

***Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐***

Date: _____

Dear: (Employee Name): _____

Wise Staffing Group and its member companies (Wise Staffing Services, Inc., Labor Source, LLC., Onesource Staffing LLC., and Resource Management Group, LLC.) desires to provide our injured employees with the most expedient and quality medical care for their work-related injuries. We have developed a modified duty plan that will allow our injured workers to return to work on a modified duty status by making accommodation for work restrictions.

You have been advised by the doctor that you have been released to modified status as of _____. The letter serves as notice to you that modified duty is available as of _____ and you should report to work at (time) _____ am/pm on this date for your assignment.

_____ _____

Worksite Address

Failure to report will be considered an unexcused absence, and you will not be paid for the days missed. We feel a strong commitment to providing gainful employment to our injured workers during their recovery from work related injuries, and we would appreciate your cooperation. If you have any questions or concerns, call your Supervisor.

I accept modified Duty ☐ I decline modified duty ☐

Employee Signature: _____ Date: _____

☐ Employee is not present in office, offer made by **telephone** and employee declined modified duty. Form sent to employee via mail on (date)_____.
☐ Employee is not present in office, offer made by **telephone** and employee accepted modified duty.

Office Managers Signature: _____


***Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐***

# DECLINE OF MEDICAL TREATMENT OR OBSERVATION

Employee's Name: _____ Date Reported: _____

Date of Injury: _____ Time of Injury: _____

Supervisor: _____ Client /Location: _____

Witness(es): _____

Nature of Injury/Condition: _____

Description of Injury [Body Part(s) Injured]: _____

_____

Brief Narrative Description of the Incident: _____

_____

I, hereby acknowledge my declination of medical treatment and/or observation offered to me by _____ for the injury or illness reported on _____. I recognize that signing this declination does not necessarilyimpact my later eligibility for Workers' Compensation benefits as subject to statute and insurer review.

At this time, I acknowledge that my supervisor/employer, in good faith, has offered andmade available to me an opportunity to seek necessary medical treatment and/or observation.

At a later time, I may request from my employer, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above-describedinjury.

_____
Employee's Signature

_____
Date

_____
Employee Representative/Witness


# INCIDENT REPORT

## NON-WORK RELATED/NEAR MISS

*Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐*

**REPORTED BY:** _____ **DATE OF REPORT**: _____

## INCIDENT INFORMATION

INCIDENT TYPE: _____ DATE OF INCIDENT: _____

LOCATION: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

INCIDENT DESCRIPTION: _____

_____

_____

_____

_____

NAME OF WITNESSES:

_____

_____

ACTION TAKEN:

_____

_____

_____

_____