Instructions for Work Accident



- Complete the top portion of: **First Report of Injury Packet**.
 - Complete **Employee's Statement**.
 - Complete **Anatomy Chart form** by circling injured part of body.
 - Sign and date bottom portion of **Authorization to Release Medical Information** form.
- Return completed forms to supervisor.
- Report to nearest healthcare provider for treatment.
- After treatment has been rendered, report back to your supervisor with all paperwork provided by the healthcare provider.

PLEASE SUBMIT INJURY REPORT TO PROPER INDIVUAL BELOW

Cheryl Wukovich

Barney Monk

OHIO EMPLOYEES DIRECT:

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3740 Carnegie Avenue

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EMPLOYEE'S STATEMENT

I,	certify that on	, 20	at	(a.m. or p.m.), I
(Name)	(D	ate)		(Time)
sustained an injury to my	D			that occured as follows:
Has this body part been previous	ously injured? Yes	No If y	es, when	?
Place incident occurred (Depr	t.,Plant,etc.)			
Did the incident occur while	you were working (on the	e clock)? □	Yes □ N	No
Did the incident occur while	you were performing you	ır reguarly as	signed jo	ob/duty? □ Yes □ No
Did the incident occur on en	mployer's property? 🗆 Y	es □ No		
Names of Witnesses:				
To whom did you report the	accident?			
Date and Time reported				
Hospital and/or Doctor				
Address of Hospital or Docto	or			
Employee address				
Social Security Number		Phone Number	er	
Date of birth	Dat	te of Hire		
Occupation	Su ₁	pervisor		
Signature of Employee				Date



ANATOMY FORM

Instructions for Employee:

Please circle the injured body part(s) then sign and date this form.

Signature of Claimant Date



WITNESS STATEMENT

Name of injured worker:		
Date of injury	Time of injury:	(a.m. or p.m.)
Place of injury:		
Description of injury:		
Description of how injury occurr	ed:	
Did you see the accident? □ Y	es 🗆 No	
Describe how you became aware	of the incident	
How did the injured person descri	ribe the accident to you?	
Who else was aware of the accid	ent?	
Was the injured employee on the	clock or on duty when the	incident occurred?
Describe any known previous inj	uries or problems this perso	on has with the same part of the body:
Any other information you wish	to provide?	
Witness's Name	Witness's Ac	ldress
Witness's Phone:		
Signature of Witness:		Date:

STANDARD AUTHORIZATION FORM

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.

FORM A - AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS) Section I First Name* M.I. Last Name* Date of Birth* Social Security Number Address City State Zip Code I hereby authorize the disclosure of health information about the above individual as follows. Disclosing Entity* (Covered Entity such as a health plan/insurer or provider) Address Telephone Number City State Zip Code Recipient (Person or Entity) * Contact Information (e.g. telephone number, email address, fax number, street address, etc.) Section III Reason for Disclosure* Health information to be disclosed* Specify time period, if desired: Release only information from the period (mm/dd/yyyy) to (mm/dd/yyyy) Section IV This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year. **Expiration Date or Event** (mm/dd/yyyy) • I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law. • I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law. may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164]. Signature of Individual* Date* (mm/dd/yyyy) Signature of Personal Representative (if applicable)* (identify relationship to individual below) Date* (mm/dd/yyyy) Relationship of Personal Representative to Individual (Personal representative shall submit proof of authority to the disclosing entity) ☐ Parent ☐ Legal Guardian ☐ Healthcare Power of Attorney ☐ Executor/Administrator ☐ Other For administrative use only: Method of Delivery (e.g. paper, fax, electronic,) Date Released

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	□ Yes	□ No
If yes, please complete the following. If no, proceed to Section II.	·	
Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if av	ailable.)	
Medicare Claim Number: Date of Birth (Mo/Day/Year)		
Social Security Number: (If Medicare Claim Number is Unavailable)	□ Female	□ Male
Section II		
understand that the information requested is to assist the requesting insurance arrange coordinate benefits with Medicare and to meet its mandatory reporting obligations unde		•

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Claimant Name (Please Print)	Claim Number	
Name of Person Completing This Form If Claiman	nt is Unable (Please Print)	
Signature of Person Completing This Form	 Date	

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Claimant Name (Please Print)	Claim Number
Medicare beneficiary and I do not provide the	vided the information requested. I understand that if I am requested information, I may be violating obligations as benefits to pay my claims correctly and promptly.
Reason(s) for Refusal to Provide Requested	d Information:



3740 Carnegie Avenue Cleveland, Ohio 44115

Phone 216-539-9582 Fax 216-426-2553

Supervisor Investigation Packet



SUPERVISOR'S REPORT

Employee Name		
Nature of Injury (State employee's complaints and body par	t injured)	
How did the incident occur?		
In view of which camera?		
Cause of the incident?		
Was the incident preventable? ☐ Yes ☐ No		
If yes, explain		
What actions have been taken to prevent a reoccurrence of i	ncident?	
Employee sent to		
Did employee report back to work? ☐ Yes ☐ No		
Does Employee have work restrictions? (List)		
Date returned to work:		
List employee's normal weekly work schedule:		
Employer's Name (Customer Name Above)		
Employer's Address (Customer Address Above)		
Supervisor's Name:	Supervisor's Phone:	
Signature of Supervisor:	Date:	