NEW BUFFALO
AREA SCHOOLS

1112 E. Clay St.
New Buffalo, MI
49117-1540

HIGH SCHOOL
(269) 469-6001

MIDDLE SCHOOL
(269) 469-6003
fax: 469-6017

ELEMENTARY
(269) 469-6060
fax: 469-6065

SUPERINTENDENT
(269) 469-6010

GUIDANCE
(269) 469-6005

TECHNOLOGY
(269) 469-6056

TRANSPORTATION
(269) 469-6009
(269) 469-6039

SOCIAL SERVICES
(269) 469-6007

ACCOUNTS PAYABLE
(269) 469-6011

BOOKKEEPER
(269) 469-6012
Fax: 469-3315

Dear EMPLOYEE:

We are committed to providing a safe working environment for all employees. Accident and injury prevention are our main goal, but if you are injured while on the job, we want to make sure you receive the care needed to get well again.

We've partnered with Saint Anthony Hospital to ensure quality medical treatment and a smooth process for workers' compensation claims. Medical treatment outside of Saint Anthony Hospital may **NOT** be eligible for compensation under the state's workers' compensation law.

All employees should be familiar with the steps necessary to seek treatment for injuries occurring at work. Our procedure is listed below.

WHEN AN EMPLOYEE IS INJURED

- Employee reports accident to immediate supervisor
- If it's not an emergency, employee immediately completes an employee report form and sees an onsite nurse, if available
- Supervisor immediately sends the employee report form to Denise Tuszynski. Within 24 hours, the supervisor should also submit a completed supervisor's report.
- Denise Tuszynski will provide the employee with a signed initial authorization to treat form. Employees **MUST** take this form to Saint Anthony Hospital for initial treatment.
- After the clinic visit, employees should provide a hard copy of the clinic's activity status report to Dan Coffman.
- Saint Anthony Hospital will work with our workers' compensation claim representative to ensure quality of care and approve future visits and prescribed treatments, including physical therapy, diagnostic tests and specialist referrals.
- Denise Tuszynski will work with employee's supervisor on restricted work options.

If you have any questions or concerns about these procedures or how workplace injuries are managed, please contact Dan Coffman at 269-469-6012 or dcoffman@nbas.org

Once again, we are committed to the safety of all employees. If you have a safety concern or any ideas for safety improvements, please contact your immediate supervisor.

New Buffalo Area Schools

The Right Choice for Today's Education

EMPLOYEE'S REPORT OF INJURY

PERSONAL INFORMATION

NAME _____ CLAIM # _____

ADDRESS _____ HOME PHONE _____ CELL PHONE _____

Gender: ☐ MALE ☐ FEMALE

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

OCCUPATION _____ EMPLOYER _____ DEPARTMENT _____

EMPLOYER ADDRESS _____

NUMBER OF DAYS PER WEEK _____ NUMBER OF HOURS PER DAY _____ NORMAL DAYS OFF _____

LENGTH OF EMPLOYMENT _____ WAGES (HOURLY RATE OF PAY) _____

INJURY INFORMATION

DATE OF INJURY _____ TIME _____ DATE INJURY REPORTED _____

Accident reported to: _____ By (name): _____

Who witnessed accident (name & address for each person listed)? _____

_____

Describe fully how injury happened (continue on back if necessary): _____

_____

_____

_____

What part(s) of your body was injured? _____

Did you stop work as a result of your accident? ☐ YES ☐ NO When: _____

Was your pay continued during any part of your disability? ☐ YES ☐ NO

If so, for what period? _____ Last day for which you were paid? _____

If not working, date you expect to return to work? _____ If you did return to work, list date? _____

From whom did you receive first medical treatment (list date)? _____

Are you still under medical treatment? _____ How often do you receive treatment? _____

NAME OF DOCTOR _____ ADDRESS _____ PHONE _____

SIGNATURE

SIGNATURE _____ DATE _____ CLAIM # _____

SUPERVISOR'S REPORT OF ACCIDENT

SCHOOL DISTRICT INFORMATION

NEW BUFFALO AREA SCHOOLS
NAME OF SCHOOL DISTRICT

P. O. Box 280, New Buffalo, MI 49117
MAILING ADDRESS

DIVISION | LOCATION | 269-469-6012 PHONE

EMPLOYEE INFORMATION

EMPLOYEE'S NAME: FIRST, MIDDLE, LAST

HOME ADDRESS

HOME PHONE | CELL PHONE

DATE OF BIRTH | ☐ MALE ☐ FEMALE GENDER | SOCIAL SECURITY NUMBER

OCCUPATION | DEPARTMENT

ACCIDENT INFORMATION

DATE OF ACCIDENT | TIME OF ACCIDENT ☐ A.M. ☐ P.M. | REGULAR WORK?

Describe injury:

Body part injured:

Witness info:

Fatality? ☐ YES ☐ NO

How did the accident happen?

Employment date: How long on this job?

Detail all machine or equipment involved:

Specify activity employee was engaged in when accident occurred:

What safety words or safety equipment was in place?

What should be done to prevent repetition?

Has it been done? ☐ YES ☐ NO If not, give reason:

NAME OF PHYSICIAN | ADDRESS

NAME OF HOSPITAL | ADDRESS

SIGNATURES

SUPERVISOR'S SIGNATURE | DATE

REVIEWED BY | DATE