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

Roger Leonhardt

Minutemen EOR Solutions

EMPLOYEES Not In Ohio

DIRECT: 216-539-9582

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EMPLOYEE'S STATEMENT

I,_____certify that on _____, 20 ____at _____(a.m. or p.m.), I
(Name) (Date) (Time)

sustained an injury to my _____that occured as follows:
(Part of Body)

(Describe the incident in detail, stating part of body injured) _____

_____

_____

_____

Has this body part been previously injured? ☐ Yes ☐ No If yes, when?_____

Place incident occurred (Dept.,Plant,etc.)_____

Did the incident occur while you were working (on the clock)? ☐ Yes ☐ No

Did the incident occur while you were performing your reguarly assigned job/duty? ☐ Yes ☐ No

Did the incident occur on employer's property? ☐ Yes ☐ No

Names of Witnesses: _____

To whom did you report the accident? _____

Date and Time reported_____

Hospital and/or Doctor _____

Address of Hospital or Doctor _____

_____

Employee address _____

_____

Social Security Number _____ - _____ - _____ Phone Number _____

Date of birth _____Date of Hire _____

Occupation _____Supervisor_____

Signature of Employee _____ Date _____

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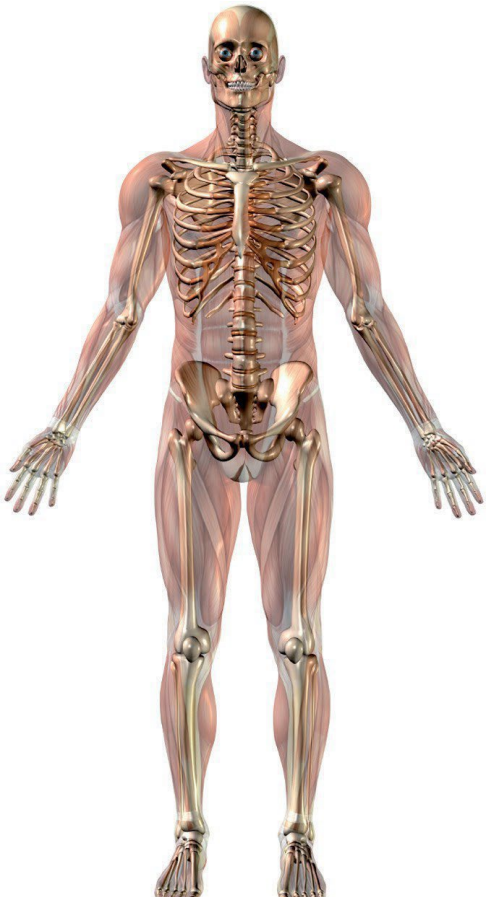
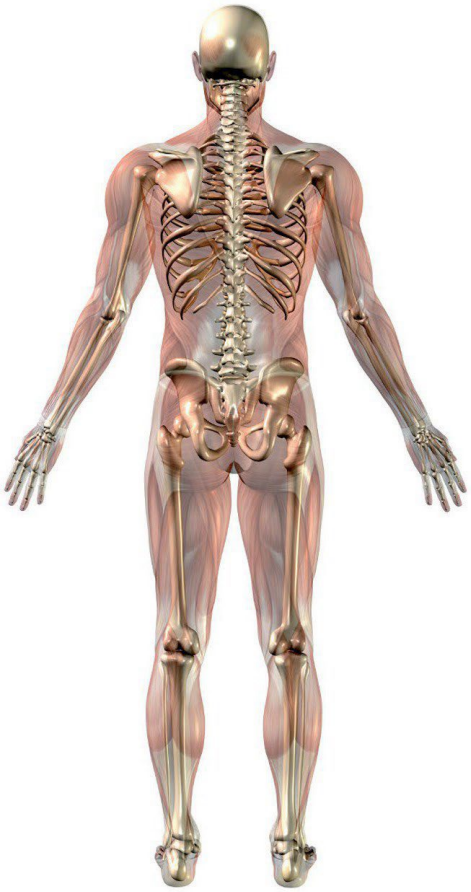
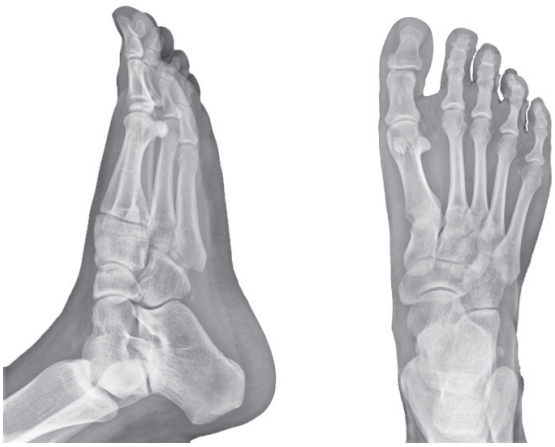
ANATOMY FORM

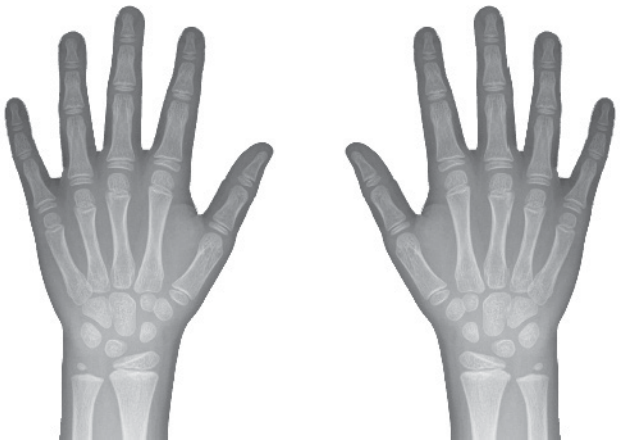
Instructions for Employee:
Please circle the injured body part(s) then sign and date this form.

Signature of Claimant _____ Date _____









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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Claimant: _____

Employer: Minutemen EOR

Claim No.: _____ D/I Injury: _____

To Whom It May Concen:

This is to authorize any physician, hospital, medical attendant, nurse, technician or others to fumish our authorized and designated representative, and/or the employer, all records, opinions, reports, x-rays, photostatic copies, abstracts or excerpts of any records or any other information or document related to my workers' compensation claim.

**** A photostatic copy or fax of this release is as valid as the original. ****

***Please list below the names and addresses of medical providers from which you have sought medical treatment for this injury and whom you are authorizing to release this information.**

_____

_____

_____

As provided by Section 4l23.65l (C) of the Ohio Revised Code, I hereby permit the release of medical information, records and reports, relative to the issues necessary for the administration of my workers' compensation claim to the Industrial Commission of Ohio, Ohio Bureau of Workers' Compensation, and 1-888-OHIOCOMP and Minute Men HR Risk Management Services, as such medical information, records and reports pertain to a condition either allowed or requested in my claim, or to consider the payment or to determine the eligibility of payment of compensation and medical benefits under my workers' compensation claim.

_____ _____

Signature of Claimant Date

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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 available.)*

Medicare Claim Number:	**Date of Birth** (Mo/Day/Year)	– –
Social Security Number: (If Medicare Claim Number is Unavailable)	– –	**Sex** □ Female □ Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) _____ **Claim Number** _____

Name of Person Completing This Form If Claimant 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.

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Section III

Claimant Name (Please Print) **Claim Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Signature of Person Completing This Form **Date**

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Supervisor Investigation Packet

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SUPERVISOR'S REPORT

Employee Name _____

Nature of Injury (State employee's complaints and body part 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 incident? _____

_____

_____

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: _____

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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 occurred: _____

_____

Did you see the accident? ☐ Yes ☐ No

Describe how you became aware of the incident _____

_____

How did the injured person describe the accident to you? _____

_____

Who else was aware of the accident? _____

Was the injured employee on the clock or on duty when the incident occurred?_____

Describe any known previous injuries or problems this person has with the same part of the body:

_____

Any other information you wish to provide? _____

_____

Witness's Name _____Witness's Address _____

Witness's Phone: _____

Signature of Witness: _____ Date: _____