

Instructions for Work Accident



- Complete the: **First Report of Injury**.
 - Complete **Employee's Statement**.
 - Complete **Anatomy Chart form** by circling injured part of body.
 - Complete, Sign and date bottom portion of **Authorization to Release Medical Information form**.
- Return completed forms to supervisor or email to rleonhardt@minutemenhr.com
- Report to nearest healthcare provider for treatment.
- After treatment has been rendered, report back to your supervisor with all paperwork or email to rleonhardt@minutemenhr.com
- Any questions concerning completing the forms contact information is below. ▲

PLEASE SUBMIT INJURY REPORT TO

Roger Leonhardt

MINUTEMEN EOR
3740 Carnegie Avenue
Cleveland, OH 44115
Toll Free: 877.541.8154
Main: 216.539.9582
Fax: 216.426.2254

DIRECT: 216-539-9582

rleonhardt@minutemenhr.com



3740 Carnegie Avenue
Cleveland, Ohio 44115
Phone 216-539-9582
Fax 216-426-2553

EMPLOYEE'S STATEMENT

I, _____ (Name) certify that on _____, 20____ (Date) at _____ (Time) (a.m. or p.m.), I

sustained an injury to my _____ (Part of Body) that occurred as follows:

(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 regularly 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 _____

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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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: _____

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.					
Section II					
Disclosing Entity* <i>(Covered Entity such as a health plan/insurer or provider)</i>					
Address				Telephone Number	
City		State	Zip Code		
Recipient (Person or Entity) *					
Contact Information <i>(e.g. telephone number, email address, fax number, street address, etc.)</i>					
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)					
<ul style="list-style-type: none"> • 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)* <i>(identify relationship to individual below)</i>					Date* (mm/dd/yyyy)
Relationship of Personal Representative to Individual <i>(Personal representative shall submit proof of authority to the disclosing entity)</i>					
<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Healthcare Power of Attorney <input type="checkbox"/> Executor/Administrator <input type="checkbox"/> Other <input type="checkbox"/> N/A					

For administrative use only:

Method of Delivery (e.g. paper, fax, electronic,)	Date Released
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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