



Occupational Injury Reporting Procedures



1. **Contact** Accord's workers' compensation department to notify us of a new injury prior to medical treatment, if possible. For serious or life threatening injuries occurring after normal business hours, notify Accord via the workers' compensation cell (405) 850-1261.
2. **Direct** the employee to seek medical attention at an Accord approved workers' compensation clinic. *Avoid emergency rooms, if possible.* They are very costly and are not a good choice for work place injuries.
3. **Give** the employee a workers' compensation ID card provided by Accord. This will give the medical provider Accord's billing information.
4. **Complete** Accord's "First Report of Injury" form and fax it to (405) 239-6584 within 48 hours of the knowledge about an injury, even if medical treatment is not required. This form is included within this workers' compensation guidebook.

If the injury does not require medical treatment, we ask that you still complete a "First Report of Injury" form. Just in case the employee needs to seek treatment for a prior injury.

5. **Instruct** the injured worker to complete the "Employee's Notice of Injury" as soon as possible and fax it to (405) 239-6584. Again, this form is included within this workers' compensation guidebook
6. **Fax** any medical documentation received by the employee or medical providers to (405) 239-6584.
7. **Notify** Accord's workers' compensation department at (800) 725-4004, if an employee misses or is directed to miss ANY time off work and also when an employee returns to work.
8. **Request** the employee to return to work in writing when the employee is released to modified or full duty. A "Modified Duty Letter" must be signed by both the injured worker and the supervisor and then faxed to the workers' compensation department at (405) 239-6584. Please notify us if you need assistance identifying a modified duty position.
9. **Update** Accord with any concerns or comments on a specific incident and continue to fax any medical documentation received by the employee or medical providers.

Remember

Report, Report, Report.

When incidents are not reported, their causes usually go uncorrected. This means that they may happen again, perhaps producing tomorrow's disabling injury or fatality.

POST IN A PROMINENT AREA

For additional contact information see reverse side.

TEAMWORK

Our goal is to take care of our valued employees. We will assist in making sure all benefits due to the employee are provided timely. To accomplish this goal, we want to be in contact with an injured employee as quickly as possible. We will explain the process of workers' compensation and the roles of Accord Human Resources and the insurance company. We believe immediate contact is vital to ensure them that we are here to assist them.

WORKERS' COMPENSATION CLAIMS:

Jeanette Flores, Workers' Compensation Administrator, (800) 725-4004 or (405) 606-6278, jflores@accordhr.com

Lori McCormick, Workers' Compensation Claims Assistant, (800) 725-4004 or (405) 606-6279, lmccormick@accordhr.com

WORKERS' COMPENSATION CERTIFICATE REQUEST:

Nikki Hunt, Risk Management Assistant, (800) 725-4004 or (405) 606-6286, nhunt@accordhr.com or fax request to (405) 239-6584.

Also available through our on-line service center, *AccessAccord*. Ask your CRC for details.

AFTER HOURS INJURY PHONE:

(405) 850-1261

SAFETY DEPARTMENT:

Shea Alexander, Safety Engineer, (800) 725-4004 or (405) 388-8198, salexander@accordhr.com

Scott Williams, Safety Engineer, (800) 725-4004 or (405) 850-0828, swilliams@accordhr.com

Jay Kamstra, Safety Engineer, (800) 725-4004 or (254) 466-3651, jkamstra@accordhr.com

DEPARTMENT MANAGER:

Karl Mohr, Director of Risk Management, (800) 641-6708, kmohr@accordhr.com

If you have any safety concerns or issues, you may contact the safety management team without fear of reprisal.



ACCORD HUMAN RESOURCES
*First Report Of Injury
Or Occupational Disease*

Phone: (405) 232-9888 (405) 239-6584
(800) 725-4004 (800) 725-4049

Completion of this report does not constitute an admission of liability

- Supervisor, please complete all the information to avoid penalties or possible rejection of claim.
- Immediately FAX or PHONE this report to Accord Human Resources.
- Emergency Care (Life, Limb, Heavy Bleeding): send injured to nearest Hospital Emergency Room and contact Accord immediately.
- Non Emergency: Please fax this report as soon as possible, within 24 hours of injury. Call us at (405) 232-9888 or 800-725-4004 if you need assistance directing care
- Injured employees should NEVER pay for Workers' Compensation medical bills. Have all bills sent to Accord Human Resources at 210 Park Ave., Suite 1200, Oklahoma City, OK 73102

EMPLOYEE INFORMATION

1. Co-employer's Name: _____ 2. Date form completed: ____/____/____
3. Employees Name: _____ 4. State of Hire: _____
5. Address: _____ City: _____ State: _____ Zip code: _____
6. Date of Birth: ____/____/____ 7. SSN: ____-____-____ 8. Home Phone (____)____-____
9. Marital Status: Divorced / Married / Single / Separated / Widowed (circle one) 10. Gender F / M
11. Number of Dependents ____ 12. Occupation / Job Title: _____ 13. Date of hire: ____/____/____
14. Rate of Pay: \$____. ____ 15. Per: Hour / Week / Month / Job / Commission (circle all that apply)
16. Average Hours per Shift: _____ 17. Circle Scheduled Work Days: S M T W TH F S
18. Will Employee be paid for entire day of Injury / Illness? Yes _____ No _____

INJURY/ILLNESS INFORMATION

19. Date of Injury/Illness: ____/____/____ 20. Date Claim Was Reported to Supervisor: ____/____/____
21. Time of Injury / Illness: ____:____ a.m./p.m. 22. Has EE returned to work? Y / N When? ____/____/____
23. If released to work *light duty*, can you provide work within the restrictions? Yes / No If yes what? _____
24. Time Employee Began Shift: ____:____ a.m./p.m. 25. Last Day Worked: ____/____/____
26. Was Employee Working Overtime at Time of Injury / Illness: Yes _____ No _____
27. Nature of Injury / Illness (bruise, laceration, poison, etc.): _____
28. Body Part(s) Affected (right hand, left leg, lower back, etc.): _____
29. All Equipment, Materials, or Chemicals Employee Was Using When Accident / Illness Occurred: _____
30. Were Safeguards or Safety Equipment Provided? Yes ___ No ___ 31. In Use? Yes ___ No ___
- If yes please list: _____

DESCRIPTION OF INJURY / ILLNESS EXPOSURE

32. How Injury or Illness / Exposure Condition Occurred. Describe the Sequence of Events and Include any Objects or Substances that Directly Injured the Employee that Made the Employee Ill: _____

33. Specific Activity the Employee was Engaged in When the Accident or Illness Occurred (driving, walking, lifting, etc.): _____

34. Work Process the Employee was Engaged in When Accident or Illness Exposure Occurred (framing, roofing, delivering, caregiving, etc.): _____
35. Was injury caused by a mechanical failure or unsafe act (circle which applies)? Y / N
36. Were other workers injured in this incident? Y / N If Yes, Whom: _____

LOCATION OF INJURY / ILLNESS

37. Did Injury/Illness Occur On Employer Premises: Yes _____ No _____
If no, specific location, address and/or directions: _____

38. City: _____ County: _____ State: _____ Zip Code: _____

ADDITIONAL INFORMATION

39. Witness (es) Name(s) and Telephone Number(s): _____

40. If the Validity of the Claim is Doubted, State Reason: _____

- Supervisor's Name (printed):** _____
- Signature:** _____ **Date:** ____ / ____ / ____

TREATMENT INFORMATION

41. Was Employee taken to a Medical Facility for Treatment? Yes _____ No _____
If No, Did Employee Receive Minor First-Aid Treatment at Job Site? Yes _____ No _____
If Yes, was Employee hospitalized? Yes _____ No _____
42. Name of Medical Facility: _____
43. Name of Physician: _____ Phone: (____) ____ - _____
44. Address: _____ City: _____ State: _____ Zip code: _____
45. Was Employee Transported by Ambulance? Yes: _____ No _____



EMPLOYEE'S NOTICE OF INJURY

210 Park Ave., Ste. 1220 Oklahoma City, OK 73102

Phone: (405) 232-9888 (405) 239-6584
 (800) 725-4004 (800) 725-4049

Employee Name (last, first, middle)		Social Security #:		Phone: ()	
Street Address		City		State Zip	
Occupation:	State where employment agreement was made:	Average weekly wage:	Length of employment: Months ____ Years ____		
Date of Accident of Last Exposure:		Time: ____AM ____PM		Place of Injury: City/County/State	
Body parts injured:	Describe in detail how the injury occurred. Include object or substance, which directly injured you.				
Treating Physician (full name):		Address:		City: State: Zip:	
Name of Co-employer			Job site location		

Are you a previously impaired person due to prior workers' compensation injury or obvious pre-existing disability caused by accident, disease, birth defect or military injury, that may impact the treatment of this injury? _____ If "Yes", please describe:

Date:	Description:	Physician:

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier an change in a material fact, or the amount of income he/she is receiving, or any change in his/her employment status, occurring during the period of receipt of such benefits.

I declare under penalty of perjury that I have examined this notice and claim, and all statement contained herein, and the best of my knowledge and belief, they are true, correct and complete.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Upon filing this Notice of Accidental Injury and Claim for Compensation, permission is given to the Administrator of the Workers' Compensation Court, the Insurance Commissioner, the Attorney General, a District Attorney, the Insurance adjuster or their designees to examine all records relating to the notice. The permission granted to the above named individuals or their designees authorizes them access to medical records, including waiver of any privilege granted by law concerning communications made to a physician or health care provider or knowledge obtained by such physician or health care provider by personal examination.

The information authorization for release may include information, which may be considered a communicable, or venereal disease which may include but not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome.

Signed this _____ day of _____, _____

Employee Signature

Print Employee Name

This form constitutes a medical authorization for release of medical records. Nothing shall be construed to waive, limit or impair any evidentiary privilege recognized by law.