To: All Staff
From: Human Resources
Re: Workers' Compensation Procedure

There are two forms that must be completed if an employee is injured. The required forms and procedures are outlined below.

First Report of Injury:

This form consists of **two pages**, and **both pages must be fully completed**. It is essential that the form is completed by both the school/location and the employee. Once complete, the form must be submitted to **Human Resources at humanresources@monroe.k12.mi.us**.

This form allows Human Resources to initiate the workers' compensation process if medical treatment was sought. Even if no treatment is sought, the form is still required, as all workplace injuries must be documented and tracked.

Please do not submit the form until **both pages are fully completed**, including documentation indicating whether treatment was sought and the required district sign-off.

Authorization to Treat:

If medical treatment is sought following an injury, the employee should take the Authorization to Treat form with them to the medical facility. This form provides the necessary workers' compensation billing information. This form does **not** need to be submitted to Human Resources. If no medical treatment is sought, the employee does not need this form.

Where to Seek Treatment:

Employees should seek medical treatment at the same occupational health facility used by Monroe Public Schools employees, if directed. This is typically an occupational health or urgent care facility. Employees should not seek treatment from a personal physician or chiropractor and should only visit the emergency room if the nature of the injury requires emergency care.

Notification:

Immediate phone notification is not required, provided the First Report of Injury is completed thoroughly and submitted as soon as possible. Please forward any medical bills, work restrictions, or additional medical documentation to Human Resources upon receipt.

If you have any questions regarding this procedure, please contact **Human Resources** at **humanresources@monroe.k12.mi.us** or by phone at **734-265-3020**.

Edustaff

Excellence in Staffing

AUTHORIZATION FOR TREATMENT
Workers Compensation

This form authorizes a health care provider to treat the following Edustaff Employee:

_____

for a work-related injury which occurred on _____

at _____.

Send all billing information to:

AmTrust Financial Services, Inc.
PO Box 89404
Cleveland, OH 44101
Policy# MWC1040642
If the bills need to be faxed, they can be faxed to 678-258-8395.

If any questions, please call 877-974-6338 ext. 140

4120 Brockton Dr. SE
Suite 200
Grand Rapids, MI 49512

Phone: 877.974.6338
Fax: 877.974.6339
E-mail: humanresources@edustaff.org

FIRST REPORT OF INJURY

Date of Report: _____/_____/_____

Date Notified Employer: _____/_____/_____

Date of Injury: _____/_____/_____ Time of Injury: _____:_____ AM/PM (circle one)

Edustaff Employee Information:

Employee Name (Last, First, Middle): _____

SSN: _____-_____-_____ DOB: _____/_____/_____ Sex: M/F (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Phone Number: _____-_____-_____ **Hire Date:** _____/_____/_____

Job Title: _____

Injury Report Information:

Job/Injury Location: _____

DISTRICT: _____

Start Time: _____:_____ AM/PM (circle one) End Time: _____:_____ AM/PM (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Witness to Injury: _____ Witness Phone Number(s): _____-_____-_____

Explain How Injury Occurred: _____

_____

_____

Nature of Injury: _____

Part of the body directly affected by the injury: _____

Last Day Worked: ____/____/_____

Was the injury fatal? Yes/No (circle one) If yes, date of fatality: ____/____/_____

Did employee seek medical treatment? Yes/No (circle one) – THIS MUST BE COMPLETED BEFORE SUBMITTING

If yes, date of treatment: _____/_____/_____

Name of treatment facility: _____

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

District Information: THIS MUST BE COMPLETED BEFORE SUBMITTING

Building Supervisor: _____
(PRINTED NAME AND SIGNATURE)

Phone Number: _____-_____-_____

Date: _____

Feedback: _____

Please return BOTH COMPLETED PAGES to Human Resources at humanresources@monroe.k12.mi.us.

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Suite 200
Grand Rapids, MI 49512

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