INTEGRITY
So Much More Than Payroll

Workers' Compensation Claim Reporting Procedures

Integrity Employee Leasing realizes that accidents will and do happen while an employee is on the job. It is our mission to ensure that if an employee is injured they are taken care of promptly and with the upmost care at one of our authorized treating facilities.

To ensure your employee is taken care of **All injuries or incidents** must be reported to Integrity Employee Leasing **immediately** regardless of the severity.

Please review and familiarize yourself with the claim reporting procedures listed below. As always if you have any questions, please call and we will be happy to address any questions or concerns you might have regarding reporting an on the job injury.

1. All employees **MUST** be informed to report **ANY** injury or incident to their immediate supervisor as soon as it happens regardless if treatment is needed or not.

2. Determine the severity of the injury or incident to determine if medical treatment is needed.

   - If it is a life threatening injury call **911** immediately.
   - If injury is not life threatening, take the employee to the closest authorized workers' compensation facility. If we have not established a location for you, please call **(941) 625-0623** and we will provide the information to you so you have it in case of injury.
   - A **MANDATORY** drug test is required for **ALL** injuries requiring medical treatment.
   - Call Integrity Employee Leasing immediately when possible and we will contact the treating facility and provide authorization for treatment.
   - If an injury occurs after business hours, contact Integrity Employee Leasing first thing the next business day.
   - Complete the Supervisors Report of Injury and fax to **(941) 625-0123**
   - If the employee refuses treatment have them complete the Employee Statement of Release and also sign the Supervisors Report of Injury stating they are electing not to seek medical treatment.

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SUPERVISOR'S INJURY REPORT

This form must be completed IN FULL IMMEDIATELY within 24 hours following an injury.
DRUG TESTING IS REQUIRED

Fax to (941) 625-0123 or (877) 428-8401

CLIENT INFORMATION

Client #: _____

Company Name_____Company Phone: (_____) _____

Address_____ZipCode:_____

EMPLOYEE INFORMATION

Employee Name _____SSN:_____-_____-_____

Employee Phone (_____)_____DOB:__/_____/_____/_____

Address _____ZipCode:_____

ACCIDENT INFORMATION

Accident Date:_____/_____/_____ Date Accident Reported to Employer:_____/_____/_____

Time of Accident:_____AM / PM County of Accident:_____

Accident Location Name and Address:_____

What was employee doing at the time of the incident? _____

Employee's description of accident:_____

_____

Injury/Illness that Occurred:_ _____

Part of the Body Affected (be specific):_ _____

Was there any equipment that contributed to the injury? ☐ Y or N ☐ Describe in detail:_____

_____

Witnesses? ☐ Y or N ☐ If Yes, please provide name(s):_____

TREATMENT

Name, Address and Phone # of Hospital or Facility providing treatment:_ _____

_____

Authorized by Employer? ☐ Y or N ☐ Employer agree with Employees description of Accident? ☐ Y or N ☐

REFUSAL OF TREATMENT

Did the injured worker refuse treatment? ☐ Y or N ☐ If Yes, Employee must sign a Statement of Release

_____ _____ _____
Supervisor Signature Print Name Date

For Internal Use Only

_____Date Received _____Employee File Data

_____Processor _____Employee/Client Data

_____IEL # _____FROI/sent & completed

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This form must be completed IN FULL IMMEDIATELY and provided to INTEGRITY EMPLOYEE LEASING within 24 hours following an injury

Attention: Workers Compensation Department

Employee Name:_____ DOB:_____

Client/Company Name:_____

EMPLOYEE STATEMENT OF RELEASE

I, the undersigned employee, sustained a job related injury on _____
Date

while working for the above-named company.

Integrity Employee Leasing's policy is that all employees who report a work-related accident are required to immediately undergo a drug test. Failure to do so may result in the denial of worker's compensation benefits. Upon being fully informed, I have voluntarily elected to:

☐ Immediately undergo a drug test and go for treatment. I understand this test needs to be performed immediately and failure to do so may jeopardize my entitlement to worker's compensation benefits.

☐ Refuse treatment and drug test.

_____ _____
Employee Signature Date

SUPERVISOR CONFIRMATION

_____ _____
Supervisors Signature Date

_____
Print Supervisor's Name

SUPERVISOR'S INJURY REPORT MUST ACCOMPANY THIS RELEASE