In the event of a workplace injury or illness for an employee, the employee must email **Michael.Matscherz@decisionone.com** within 24 hours.

Before calling, the caller must gather all the necessary information. The following information will be requested by to file a claim

Use this worksheet to record the information that the caller will need when reporting the injury.

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| Has the incident already been reported to a nurse? (Coventry Nurse, a nurse triage service used by DecisionOne onsites) | If yes, the IMA #:       |
| **About the Incident** |  |
| Address at which the incident occurred? |       |
| State in which the incident occurred? |       |
| City in which the incident occurred? |       |
| Date on which the incident occurred? |       |
| Time of day when the incident occurred? |       |
| Date on which employer (DecisionOne) was notified of the incident? |       |
| Time of day when the employer (DecisionOne) was notified of the incident? |       |
| **Employee Information** |  |
| Full Name (First, Middle, Last) |       |
| Job Title: |       |
| Home Phone Number: |       |
| Mobile Phone Number: |       |
| Work Phone Number: |       |
| Home address of the injured person? (street address, city, state, ZIP, county, country) |       |
| Date of birth of the injured person? |       |
| Marital status of the injured person? (according to the injured person’s W-4 record in DecisionOneTrack) |       |
| Gender of the injured person? | Male or Female:       |
| Number of dependents of the injured person? (according to the number of federal deductions on the injured person’s W-4 record in DecisionOneTrack) |       |

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| **About the Injured Person’s Job** |  |
| Job title of the injured person at the time of the injury? |       |
| Status? | Permanent (in-house) or Temporary (field employee):       |
| Was the job full time (more than 35 hrs/week) or part time (less than 35 hrs/week)? |       |
| Hire date? (start date of the assignment) |       |
| Termination date, if applicable? (end date of the assignment) |       |
| Hourly salary rate? (pay rate at the time of the injury) |       |
| Normally scheduled hours per day? |       |
| Name of supervisor on assignment? (first, middle initial, last). |       |
| Job title of supervisor on assignment? |       |
| Contact phone number of supervisor on assignment? |       |
| **Details About the Incident** |  |
| Description of the incident?(include what employee was doing, work process, cause, injury and body part) |       |
| **About the Medical Provider** |  |
| Has medical treatment been provided? | Yes/No (if no, skip this section):       |
| Name of doctor? |       |
| Address of doctor? (street address, city, state, ZIP, county, country). |       |
| Telephone number of doctor? |       |
| Name of hospital or clinic? |       |
| Address of hospital or clinic, if different from the doctor’s address? (street address, city, state, ZIP, county, country). |       |
| Telephone number of hospital or clinic? |       |
| Type of transportation taken to receive treatment? (ambulance, 3rd party, drove self, air transport, etc.) |       |
| **About the Witnesses** |  |
| Did anyone witness the incident? | Yes/No (if no, skip this section):       |
| Witness #1 (first name, last name, home phone, work phone) |       |
| Witness #2 (first name, last name, home phone, work phone) |       |
| Witness #3 (first name, last name, home phone, work phone) |       |
| Witness #4 (first name, last name, home phone, work phone) |       |

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| **About Lost Time** |  |
| Will (or did) the injured person miss work beyond the date of the incident? |       |
| Date of last day worked? |       |
| Date returned to work? |       |
| Was the injured person’s salary continued? (check with the Loss Control Dept. for this information) |       |
| Received full wages? (if salary was continued per previous question, then full wages were received) |       |
| **About the Location of the Incident(if different from work location)** |  |
| Name of location? (residence/business, name of business, type of facility, etc.) |       |
| Address of location? (street address, city, state, ZIP, county, country) |       |
| Did the incident occur on the client’s (customer’s) premises? |       |
| **Additional Information** |  |
| For which state are payroll taxes withheld for the injured person? (typically, the state where the person is working) |       |
| The DecisionOne Department ID to which the employee was assigned at the time of the incident? |       |
| The DecisionOne job number to which the employee was assigned at the time of the incident? |       |
| Name of the customer company to which the injured person was assigned at the time of the incident? |       |
| The primary language that the injured person speaks? |       |
| Type of medical treatment received by the injured person after the incident? |       |
| **OSHA Information** |  |
| Was the injured person treated in an emergency room? |       |
| Was the injured person hospitalized overnight as an in-patient? |       |
| OSHA Case # or OSHA 300 Log # (from VTC 1079) or other equivalent ID # ? |       |
| Time of day that the injured person began work on the day of the incident? |       |
| The object or substance that directly harmed the injured person? |       |
| What was the injured person doing when the incident occurred? (be specific) |       |