Livingston **EDUCATIONAL SERVICE** Agency

WORKERS' COMPENSATION PROCESS FOR FILING A CLAIM

The following information is being provided in order to help you as you progress through your workers' compensation claim:

On the date of injury/incident, please complete the Employee Incident Report immediately – not to exceed 24 hours.

- If treatment is required, you must obtain an Authorization for Treatment *(valid only when signed by Supervisor or their designee)* at the Agency's Board Approved Occupational Clinic, RediCare.

- If authorized to leave work early to receive medical attention/treatment *on the day the work-related injury occurs*, you will not lose pay, nor use sick/personal time for the portion of the day not worked.

- You may *only* receive treatment from RediCare during your first twenty-eight (28) days after your injury. If, after the initial twenty-eight (28) days, you prefer to seek treatment from your own physician, please contact your CCMSI representative as listed below.

- If you are taken off work due to a work-related injury, please review the information below; it is your responsibility to:

    - Request an excused absence in paper form.

    - Inform the physician to contact your CCMSI representative for authorization any referrals; the Agency is not able to authorize any treatment beyond the initial Authorization for Treatment.

    - Promptly submit all physician statements and/or doctor notes to Human Resources.

    - Keep, or schedule, recommended appointments, as failure to do so may result in loss of workers' compensation claim benefits.

CCMSI
2364 Woodlake Drive, Suite 100
Okemos, MI 48864
Toll free: 866.204.0808

Workers' Compensation Claims Adjuster(s) for claims involving employees having missed 0 – 7 calendar days of work:
Tara Kavanagh
Haley Magwood

Workers' Compensation Claims Adjuster(s) for claims involving employees having missed 8 – 15 calendar days of work:
Amanda Parsons

Workers' Compensation Claims Adjuster(s) for claims involving employees having missed 15+ calendar days:
Mark Rue

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EMPLOYEE INCIDENT REPORT

EMPLOYEE: Please provide the information requested.

Name: ______________________________ Telephone Number: ______________

First Name *Last Name*

Address: ______________________________

Date of Birth: ______________ Marital Status: ______________ Gender: ______________

Job Title: ______________ Date of Incident: ______________ Date Reported: ______________ Name of Witness: ______________

What type of injury did you incur? ______________________________

Example: cut, bruise, bite, etc.

What part(s) of your body were injured? ______________________________

Describe, fully, how the incident/injury occurred:

____

Was Nurse called? Yes No

Time: ______________ Date: ______________

Treatment Required:

____

Authorization for Treatment given? Yes No Refused

Program Supervisor Notified: Yes No Date: ______________

Signature: ______________________________

Date: ______________
[mm/dd/yyyy]

SUPERVISOR SIGNATURE

Signature: ______________________________

Date: ______________
[mm/dd/yyyy]