EASTERN
MICHIGAN UNIVERSITY

AUTHORIZATION FOR TREATMENT

(Work related injury)

This form authorizes treatment for a work related injury at the EMU designated clinics listed below ***only***:

MICHIGAN URGENT CARE & OCCUPATIONAL HEALTH

Ann Arbor– 3280 Washtenaw Avenue, Ann Arbor (8am-10pm)
Brighton – 2300 Genoa Business Park Drive Suite 120, Brighton (8am-8pm)
Canton – 2050 Haggerty Road Suite 140, Canton (8am-8pm)
Dundee – 100 Powell Drive Suite 8, Dundee (8am-8pm)

AFTER HOURS ONLY:
St. Joseph Mercy Ann Arbor Hospital - 5301 McAuley Drive Ypsilanti, MI 48197

ATTN: Registration

Employer Name: **EASTERN MICHIGAN UNIVERSITY**

Employee Name: _____

Date of Injury: _____

Body part: _____

The above employee is authorized to receive treatment for the injury indicated above.

Please send medical reports and any accompanying documents immediately after treatment to:	Please send billing to:
Eastern Michigan University **ATTN: Tracey Piercecchi - tpiercec@emich.edu** **Telephone - 734-487-1357**	**York Risk Services Group** **PO Box 620** **Howell, MI 48844** **877-365-9774 (fax)**

For authorization of any additional diagnostic testing and/or specialist referral, please contact York as follows:
Tanisha Lee – Medical Claims Adjuster – 517-338-3294
Shannon Yarkosky – Senior Claims Adjuster – 517-338-3290

EMPLOYER AUTHORIZATION

Supervisor Printed Name: _____

Supervisor Signature: _____

Your signature indicates the employee is seeking medical treatment for a claimed work-related injury.

Supervisor Telephone: _____ Date: _____

EASTERN MICHIGAN UNIVERSITY

Department of Risk Management and Workers' Compensation
11 Welch Hall ▫ 734-487-1357 (phone) ▫ injury.report@emich.edu ▫

Procedures for Occupational Injuries or Illnesses

THE FOLLOWING SITUATIONS *MUST* BE REPORTED IMMEDIATELY TO THE WORKERS' COMPENSATION OFFICE (OR DPS IF AFTER HOURS, WEEKEND OR HOLIDAY):

- ANY ACCIDENT RESULTING IN A FATALITY;
- ANY HOSPITALIZATION OF 1 OR MORE EMPLOYEE(S) SUFFERING INJURY FROM THE **SAME ACCIDENT** ASSOCIATED WITH THEIR EMPLOYMENT;
- ANY HOSPITALIZATION OF 1 OR MORE EMPLOYEE(S) SUFFERING ILLNESS FROM EXPOSURE TO THE **SAME HEALTH HAZARD** ASSOCIATED WITH THEIR EMPLOYMENT

For all other work-related injuries/illnesses:

1. Injured employee must notify a supervisor after a work related injury or illness occurs.

2. Employee and Supervisor must complete a ***Report of Employee Occupational Injury*** form in its **entirety** and attach additional information or reports (example: police reports, departmental reports, etc.) when applicable. This report must then be forwarded to EMU's Department of Risk Management and Workers' Compensation ("WC Office") office for processing, no later than 24 hours after the injury occurs. Failure to submit this report may delay the claim, or cause it to be denied.

3. A supervisor must provide the employee with the completed ***Authorization for Treatment*** form. Include a copy of this form when submitting the injury report to the WC Office. In the event of a life-threatening emergency, a supervisor or designated employee should contact the WC Office as soon as possible to advise of the emergency.

The Workers' Compensation Act allows an employer to direct care for its injured employees for 28 days.

Except in the case of a life-threatening emergency, employees must seek medical treatment at one of the clinics designated by EMU. The list is included on Page 1 of the injury report and on the Authorization for Treatment form.

Failure to seek treatment at one of these clinics may cause your claim to be delayed or denied. Exceptions may be made for a life threatening emergency.

It is the employee's responsibility to contact a Supervisor, and/or the WC Office immediately after treatment for the following:

1. If the injury results in missed work days;
2. To provide medical documentation from treatment and/or confirm that the WC Office has received the documentation from the Provider directly.

For more information please visit http://www.emich.edu/riskmanagement/workers_compensation.php

EASTERN MICHIGAN UNIVERSITY

Department of Risk Management and Workers' Compensation

Report of Employee Occupational Injury – *EMPLOYEE SECTION*

Employee completes Pages 1-2. Employee *and* Supervisor sign on page 2.
All fields must be completed or your claim may be delayed.
If you will miss any work beyond the date of injury, it is your responsibility to contact your Supervisor, and the Workers' Compensation Office with this information.

You must seek medical treatment at one of the following designated clinics. Failure to seek treatment at an EMU designated clinic may delay or cause your claim to be denied.

Michigan Urgent Care & Occupational Health – Ann Arbor 3280 Washtenaw Avenue Ann Arbor, MI 48104 734-389-2000 8:00 am – 10:00 pm 7 days a week	**Michigan Urgent Care & Occupational Health - Canton** 2050 Haggerty Road, Suite 140 Canton, MI 48187 734-259-0500 8:00 am – 8:00 pm 7 days a week
Michigan Urgent Care & Occupational Health - Brighton 2300 Genoa Business Park Dr. Ste.120 Brighton, MI 48114 810-844-0400 8:00 am – 8:00 pm 7 days a week	**Michigan Urgent Care & Occupational Health - Dundee** 100 Powell Drive, Suite 8 Dundee, MI 48131 734-823-5900 8:00 am – 8:00 pm 7 days a week
AFTER HOURS ONLY: **St. Joseph Mercy Hospital** **5301 McAuley Drive** **Ypsilanti, MI** If you seek after-hours treatment at this location, you are required to forward documentation from the visit to your Supervisor and/or the EMU WC Office by the next business day. Any follow up treatment needed will be directed by York Risk Services Group, EMU's third-party administrator for WC claims. Failure to provide the documentation and/or seek follow up treatment as directed by York may delay your claim or cause it to be denied.	

Employee Information - ALL FIELDS MUST BE COMPLETED:

Your Social Security # is required for all claims. For privacy, this information will be extracted from EMU's file.

Name: _____ EID #: _____
Last First Middle

Home Address: _____
Number Street (Apt #) City State Zip Code

Phone #: (____) _____ Birthdate: _____
Home Work (mm/dd/yy)

Gender: **M F** Date of hire by the University: _____ Do you claim on-the-job injury? **Y N**
(mm/dd/yy)

Retirement Plan: **MPSERS** **TIAA –CREF** Marital Status: _____

Injury/Illness Information - ALL FIELDS MUST BE COMPLETED:

Date of Injury/Illness: _____ Time shift began on date of injury/illness: _____ a.m. / p.m.
(mm/dd/yy)

Time injury/illness occurred:_____ a.m. / p.m.

Location injury/illness occurred: _____
(Be SPECIFIC: Building, Floor, Room, etc. Ex: Northwest Stairwell of Mark Jefferson, 3rd Floor)

What were you doing **just before** the injury/illness occurred? _____
(Be SPECIFIC: Describe activity, tools/ equipment used, etc.)

_____

_____

What were you doing **when** injury/illness occurred? _____
(Be SPECIFIC: Task being performed. Example: Mopping stairs)

_____

How did injury/illness occur? _____
(Be SPECIFIC: Describe fully the events that led up to the accident. Example: Slipped on wet stairs and dropped bucket of water on foot)

_____

_____

What object or substance directly harmed you (if any): _____
(Example: chlorine, concrete floor, bucket of water)

List any witnesses to the accident: _____
(First and Last names)

Injury Information - ALL FIELDS MUST BE COMPLETED:

What body part(s) is affected? _____
(Example: Left Foot/Ankle **BE SPECIFIC** Right, Left, Thumb, Great toe, pinky finger, etc.)

Nature of injury: _____
(Example: Sprain, bruise, cut)

Did you seek medical attention? **Y** **N** If yes, where: _____

When did you receive medical attention? _____
Date Time

Date and time reported to Supervisor: _____ Was it reported the day it occurred? **Y** **N**
Date Time

If no, why was there a delay in reporting? _____

Signature Information:

I, the undersigned employee, acknowledge that the above statement is true, and the accident and injury occurred within the course of my employment at Eastern Michigan University.
Providing false information is cause for discipline, up to and including dismissal from employment.
It may also be cause for criminal prosecution.

Print Employee Name: _____

Signature of Employee: _____ Date: _____

Employee email address: _____

Print Supervisor Name: _____

Signature of Supervisor: _____ Date: _____
(Signifies receipt of employee's report but does not acknowledge content as fact)

EASTERN MICHIGAN UNIVERSITY

Department of Risk Management and Workers' Compensation

Report of Employee Occupational Injury – Supervisor section

In the case of a life-threatening emergency, employee should seek medical treatment at the nearest medical facility.

Employee completes and signs pages 1-2, prior to Supervisor signature on page 2. Supervisor signs page 2, and completes/signs pages 3-4, prior to providing the entire report to the Workers' Compensation office.

Please type or print legibly. *All fields must be completed*.

If employee is seeking medical treatment, provide employee with a completed Authorization for Treatment form, and forward a copy with this report to the Workers' Compensation Office.

Advise employee, if they will miss any work beyond the date of injury, it is their responsibility to contact you, and the Workers' Compensation Office with this information.

ALL FIELDS MUST BE COMPLETED

Employee Information:

Employee's Name: _____
Last First Middle

Employee's Classification and Grade: _____ (Example: FM-10) Job Title: _____ (Example: Groundskeeper)

Type of Employee: **FT** **PT** **Temp** **Student** (Circle One) Fund: ☐ General ☐ Auxiliary ☐ Other

Department: _____
(Example: Physical Plant)

Date of Injury/Illness: _____ Time injury/illness occurred: _____ a.m. / p.m

Date reported to Supervisor: _____ Time reported to Supervisor: _____ a.m. / p.m

Employee's work schedule: ☐ S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sa Time: _____

Medical Treatment:

Where did employee seek medical treatment? _____

Lost time information:

Did employee lose full days away from work due to alleged work related injury? **Y** **N**

If yes, list all days missed of work: _____

Safety Information:

Does employee's statement coincide with your findings? **Y** **N**

If no, state any inconsistencies you found while investigating employee's statement of what happened (including speaking to any witnesses' employee has listed:

_____

_____

Did the injury/illness result from a violation of a rule that is clearly announced and regularly enforced? **Y** **N**

If yes, please describe:

_____

_____

Do you dispute this injury? **Y** **N** If yes, please describe: _____

_____

Please provide any additional information here, or contact the WC Office: _____

_____

_____

Supervisor Information:

Name of Supervisor (Please **PRINT**): _____

Signature of Supervisor: _____ Date: _____

Supervisor's Phone #: _____

Supervisor's email address: _____

Deliver *completed* report to:
Risk Management and Workers' Compensation
ATTN: Tracey Piercecchi - 11 Welch Hall
-or-
injury.report@emich.edu

For Risk Management Purposes ONLY

Initial Report: RO ☐ MO ☐ IND ☐ Date entered into iVOS: _____

Division: _____ Department: _____

Job title: _____

Claim Number: _____