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. If the employee requires medical treatment, a supervisor must provide the employee with a 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 listed on Page 1 of the injury report.

(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](http://www.emich.edu/riskmanagement/workers_compensation.php)
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.

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Address</th>
<th>Phone No.</th>
<th>Hours</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washtenaw Urgent Care</td>
<td>3280 Washtenaw Avenue, Ann Arbor, MI 48104</td>
<td>734-389-2000</td>
<td>8:00 am – 10:00 pm</td>
<td>7 days</td>
</tr>
<tr>
<td>Western Wayne Urgent Care</td>
<td>2050 Haggerty Road, Suite 140, Canton, MI 48187</td>
<td>734-259-0500</td>
<td>8:00 am – 8:00 pm</td>
<td>7 days</td>
</tr>
<tr>
<td>Brighton Urgent Care</td>
<td>2300 Genoa Business Park Dr. Ste.120, Brighton, MI 48114</td>
<td>810-844-0400</td>
<td>8:00 am – 8:00 pm</td>
<td>7 days</td>
</tr>
<tr>
<td>Dundee Urgent Care</td>
<td>100 Powell Drive, Suite 8, Dundee, MI 48131</td>
<td>734-823-5900</td>
<td>9:00 am – 9:00 pm</td>
<td>7 days</td>
</tr>
<tr>
<td>AFTER HOURS ONLY:</td>
<td>St. Joseph Mercy Hospital, 5301 McAuley Drive, Ypsilanti, MI</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

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 #: ( ) Home Work Birthdate: __________________________

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:

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. Example: 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:

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: ____________________________________________________________ Date: ____________
Signature of Employee: _____________________________________________________________ Date: ____________
Employee email address: ____________________________________________________________

Print Supervisor Name: ____________________________________________________________ Date: ____________
Signature of Supervisor: ____________________________________________________________
(Signifies receipt of employee’s report but does not acknowledge content as fact)
Employee Information:

Employee’s Name: __________________________________________________________________________  

Last                             First                                              Middle

Employee’s Classification and Grade: __________________________ Job Title: _________________________

(Example: FM-10)         (Example: Groundskeeper)

Type of Employee: FT     PT       Temp       Student

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, last date worked: __________________________ Date employee returned to 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 or have additional information regarding this injury?  Y  N

If yes, please provide additional information here, or contact the WC Office: _______________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Supervisor Information:

Name of Supervisor (Please PRINT): ___________________________________________________________

Signature of Supervisor: ____________________________ Date: __________________

Supervisor’s Phone #: ____________________________ Times available: _______________________

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: _______________________________________________________________________
AUTHORIZATION FOR TREATMENT
(Work related injury)

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

Washtenaw Urgent Care – 3280 Washtenaw Avenue, Ann Arbor (8am-10pm)
Western Wayne Urgent Care – 2050 Haggerty Road Suite 140, Canton (8am-8pm)
Dundee Urgent Care – 100 Powell Drive Suite 8, Dundee (9am-9pm)
Brighton Urgent Care – 2300 Genoa Business Park Drive Suite 120, Brighton (8am-10pm)

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:

Eastern Michigan University
ATTN: Tracey Piercecchi - tpiercec@emich.edu
Telephone - 734-487-1357

Please send billing to:
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:
Jenny Killips – 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: _______________________

Authorization Form – 5.31.17