Avitus Group - Employee Injury Report

Instructions:

- **All injuries must be reported to Avitus Group on the same shift that they happened.** *Questions?* Just call us.
- Please answer all of the questions below as best you can. You will be contacted if more information is needed.
- **Do not delay reporting an injury** if all of the information is not available. Answer as many questions as you can.
- **Fax this form <u>toda</u>y to:** (406) 869-7598 ■ **Attention:** Safety & Risk Management Department

1. Business Name: _____ Location or Store # (if any): _____
2. Street Address: _____
3. City/Town:_____ State: _____ Phone: (_____) _____-_____
4. Employee Name:_____ Job Position/Title: _____
5. Employee's Date of Birth: _____/_____/_____ Is This a Full-Time Employee? ❒ Yes ❒ No
6. Employee's Mailing Address (Address, City, State & Zip): _____
7. Employee's Contact Phone Numbers: (_____) _____-_____ *or* (_____) _____-_____
8. Date Supervisor Was Notified of Injury: _____/_____/_____ How? _____
9. Supervisor's Name: _____ Supervisors Contact Phone: (_____) _____-_____
10. Date and Time of Injury: _____/_____/_____ in County: _____ State: _____
11. Location where the injury happened (shop, job site address, etc.): _____
12. What was the employee doing when injury happened: _____
13. Names(s) of Witnesses: _____
14. Treatment? ❒ None Needed ❒ First Aid ❒ Emergency Dept. ❒ Clinic/Dr. Office ❒ Other _____
15. Was Professional Medical Treatment Required? ❒ Yes – *Continue with this question* ❒ No – Go to #16
    - ■ Name and Location of Medical Provider: _____
    - ■ Phone Number of Medical Provider: (_____) _____-_____
16. Was more than 1 day lost from work? ❒ Yes – *Continue with this question* ❒ No – Go to #17

    If Time Was Lost From Work:
    - ■ First Full Day Off Work: _____/_____/_____ ■ Number of Workdays Lost?_____ Days
    - ■ Date Returned to Work: _____/_____/_____ ■ Number of Days on Restrictions?_____ Days
17. Employee's Usual Work Schedule:_____ Usual Days Off:_____
18. Body Part(s) Injured (right arm, left ankle, back, etc.): _____
19. Describe the Injury (i.e., sprain, strain, fracture, etc.): _____
20. How Did the Injury Happen (cause of injury, use additional pages if needed)?

_____

_____

21. What actions, events or conditions contributed most directly to this Injury (use additional pages if needed)?

_____

22. Corrective Actions Taken (*or will be taken*) on (or by) Date: _____/_____/_____

_____

23. Do you question <u>an</u>y aspect of this injury? ❒ No ❒ Yes – If *"Yes"* please explain below – or call us.
24. Are there any other comments *or* information that we should know about (use additional pages if needed)?

_____

_____

25. Name/Title of person completing form: _____ Phone Number: (_____) _____-_____

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED TO OSHA WITHIN 8 HOURS AND TO THE ICA WITHIN 24 HOURS.

An employer must on this form notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, arising out of and in the course of employment.

ARIZONA REVISED STATUTES 23-908 & 23-1061

MAIL ORIGINAL TO:
INDUSTRIAL COMMISSION OF ARIZONA
P.O. Box 19070
Phoenix, Arizona 85005-9070

FOR CARRIER USE ONLY
Doc Type: **IR101**

FOR OSHA PURPOSES ONLY
OSHA Case No. _____
Recordable Injury _____
Non-Recordable Injury _____

MAIL COPY TO: COPPERPOINT INSURANCE COMPANIES
3030 N. 3rd Street
Phoenix, AZ 85012
Phone: 1.800.231.1363
Fax: 1.800.356.4867
Web: copperpoint.com

Please check appropriate company
- ❑ CopperPoint Mutual Insurance Company
- ❑ CopperPoint Indemnity Insurance Company
- ❑ CopperPoint American Insurance Company
- ❑ CopperPoint National Insurance Company
- ❑ CopperPoint Casualty Insurance Company
- ❑ CopperPoint Premier Insurance Company
- ❑ CopperPoint General Insurance Company
- ❑ CopperPoint Western Insurance Company

EMPLOYER'S NAME

OFFICE ADDRESS

EMPLOYEE 1. LAST NAME | FIRST NAME | M.I.

2. SOCIAL SECURITY NUMBER | 3. BIRTHDATE

4. HOME ADDRESS (NUMBER & STREET/MAILING) | APT. #

CITY | STATE | ZIP CODE

5. (AREA CODE) TELEPHONE | DATE OF HIRE

6. SEX ❑ M ❑ F | 7. MARITAL STATUS SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑

EMPLOYER

8. EMPLOYER'S NAME | 9. POLICY NUMBER | 10. NATURE OF BUSINESS (MANUFACTURING, ETC.)

11. OFFICE ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 12. TELEPHONE

ACCIDENT

13. DATE OF INJURY OR ILLNESS | 14. TIME OF EVENT ❑ A.M. ❑ P.M. | 15. TIME EMPLOYEE BEGAN WORK ❑ A.M. ❑ P.M. | 16. DATE EMPLOYER NOTIFIED OF INJURY

17. LAST DAY OF WORK AFTER INJURY | 18. DATE OF RETURN TO WORK | 19 EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED

20. CLASS CODE ON PAYROLL REPORT | 21. EMPLOYEE'S ASSIGNED DEPARTMENT | 22. DEPARTMENT NUMBER | 23. DID INJURY OCCUR ON EMPLOYER PREMISES? ❑ YES ❑ NO

24. ADDRESS OR LOCATION OF ACCIDENT | CITY | COUNTY | STATE | ZIP CODE

25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." Examples: "strained back"; "chemical burn."

26. PART OF BODY INJURED | SIDE INJURED RT ❑ LT ❑ | 27. FATAL ❑ YES ❑ NO | 28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH

29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ❑ YES ❑ NO | NAME OF PHYSICIAN OR OTHER HEALTHCARE PROFESSIONAL | ADDRESS (STREET, CITY, STATE & ZIP CODE)

30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ❑ YES ❑ NO | IF HOSPITALIZED, HOSPITAL NAME | ADDRESS (STREET, CITY, STATE & ZIP CODE)

31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON

CAUSE OF ACCIDENT

32. **WHAT HAPPENED?** Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

33. **WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?** Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.

34. **WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ❑ YES ❑ NO | 37. HOURS PER DAY EMPLOYEE WORKED FROM ❑ A.M. ❑ P.M. THRU ❑ A.M. ❑ P.M. | 38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ❑ YES ❑ NO | 39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY

IMPORTANT IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

40. DATE OF LAST HIRE | 41. WAS WORKER PAID FOR DAY OF INJURY? ❑ YES ❑ NO IF YES, $ | 42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ❑ YES ❑ NO

43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR | 44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE $ PER HOUR ❑ DAY ❑ WEEK ❑ MONTH ❑ | 45. IS EMPLOYEE FURNISHED ❑ LODGING ❑ BOARD ❑ BOTH VALUE $

46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEDING INJURY $ (Example: If injured April 8, give earnings from March 9 thru April 7) | 47. DOES EMPLOYEE CLAIM DEPENDENTS? ❑ YES ❑ NO

IMPORTANT IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55

48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR | 49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK

50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEDING INJURY FROM THRU $ | 51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $

52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY | 53. WAGE BEFORE INCREASE $ | 54. WAGE AFTER INCREASE $ | 55. GROSS EARNINGS FROM DATE OF INCREASE THROUGH DAY PRIOR TO INJURY $

AUTHORIZED SIGNATURE | DATE | AUTHORIZED SIGNATURE | TITLE

NOTE TO EMPLOYER: 1. Mail one copy to the Industrial Commission within 10 days.
2. Mail one copy to your insurance carrier within 10 days
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

*The mandatory requirement that the Social Security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the Social Security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of Social Security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the Social Security number.

PRIORITY
BUILDING SERVICES, LLC.

INJURY STATEMENT

DATE OF INJURY: _____

REGARDING: _____ DATE: _____

NAME OF PERSON GIVING STATEMENT: _____

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OTHER COMMENTS:

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SIGNATURE OF PERSON GIVING THE STATEMENT DATE

DECLINE OF IMMEDIATE MEDICAL ATTENTION FORM
FORMA DE RENUNCIA DE ATENCIÓN MÉDICA INMEDIATA

Client-Employer Name/Nombre del Cliente-Empleador:

PRIORITY BUILDING SERVICES, LLC

Date/Fecha: _____ Time/Tiempo: _____

Location/ Ubicación:

_____

_____

By signing below I recognize that/Reconozco que por firmando abajo:

I, _____, was offered medical care and transportation to a medical facility due to a work-related injury that I reported to my supervisor on _____. However, I do not wish to utilize the medical attention at this time. Nevertheless, if at a later time there is a need for me to seek medical attention due to the same work-related injury I will contact my supervisor on this matter immediately. It is of my own free will that I have signed this document without pressure or threats.

Yo, _____, fui ofrecido/a cuidado médico y transporte a un centro médico debido a un accidente de trabajo que reporté a mi supervisor en el dia _____. En este momento, yo no deseo utilizar los servicios médicos ofrecidos por mi supervisor. Pero, si en el futuro hay necesidad de obtener la atención médica debido a este accidente de trabajo yo le avisaré a mi supervisor para pedirle la información necesaria. Es por voluntad propia que he firmado este documento sin presión o amenazas.

_____ _____
Employee's Name/Nombre del Empleado Employee's Signature/Firma del Empleado

_____ _____ [M] OR [F]
Employee's Phone/Numero del Empleado Age/Edad Gender/Género

_____ _____
Supervisor's Name/Nombre del Supervisor Supervisor's Signature/Firma del Supervisor