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>today</u> 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)?

____

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

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

____

23. Do you question <u>any</u> 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)?

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

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Office Mail Address	Location . . . If different from mailing address	Telephone	
City State Zip	INSURER	THIRD-PARTY ADMINISTRATOR	

EMPLOYEE

First Name M.I. Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Home Address (Number and Street)	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
City State Zip	Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No	How long has this person been employed by you in Nevada?		
In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:		
Telephone	Is the injured employee a corporate officer? ☐ Yes ☐ No . . . sole proprietor? ☐ Yes ☐ No . . . partner? ☐ Yes ☐ No	Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No		

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
Address or location of accident (Also provide city, county, state) (if applicable)			Accident on employer's premises? (if applicable) ☐ Yes ☐ No
What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)			
How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.			

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)		Witness	Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No
Part of body injured or affected	If fatal, give date of death	Witness	
Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)		Witness	
		Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No	Will you have light duty work available if necessary? ☐ Yes ☐ No
If validity of claim is doubted, state reason		Location of Initial Treatment	
Treating physician/chiropractor name		Emergency Room ☐ Yes ☐ No	Hospitalized ☐ Yes ☐ No
IMPORTANT	How many days per week does employee work?	From ☐ am ☐ pm To ☐ am ☐ pm	Last day wages were earned
Scheduled days off S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐		Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No	

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
Was the employee hired to work 40 hours per week? ☐ Yes ☐ No	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know	

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	Emloyee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY	On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.	Employer's Signature and Title	Date

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

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

<u>DECLINE OF IMMEDIATE MEDICAL ATTENTION FORM</u>
<u>FORMA DE RENUNCIA DE ATENCIÓN MÉDICA INMEDIATA</u>

Client-Employer Name/Nombre del Cliente-Empleador:

PRIORITY BUILDING SERVICES, LLC

Date/Fecha: ___________________________ Time/Tiempo: ___________________

Location/ Ubicación:

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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