

Incident Reporting Packet

Employee/ First Name: _____ Last Name: _____

Company: _____ Position: _____

Date of Hire: _____

When an accident occurs, no matter how minor, please call your supervisor immediately and report the incident. If the injury occurs in the evening or weekend/holiday, please call Costello Safety Consulting at (832) 786-8814. If the injury is life threatening, please contact 911 and then report the incident. Make sure that the main office receives the required incident reports within 24 hours.

Checklist

I. Accident Reporting Packet

- | | |
|---|----------------|
| 1. First Report of Injury | Yes ___ No ___ |
| 2. Supervisor Accident Report | Yes ___ No ___ |
| 3. Employee Accident Report | Yes ___ No ___ |
| 4. Witness Accident Report | Yes ___ No ___ |
| 5. Consent for Drug/Alcohol Screen Testing | Yes ___ No ___ |
| 6. Employee Voluntary Refusal to see a Doctor | Yes ___ No ___ |
| * Only if employee feels he/she does not need to see a doctor | |
| 7. Authorization for Release of Medical Information | Yes ___ No ___ |

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>	
3. Social Security Number - -	4. Home Phone ()	5. Date of Birth (m-d-y) - -	
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>			
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>		8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>	
9. Mailing Address Street or P.O. Box			
City	State	Zip Code	County
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>			
11. Number of Dependent Children		12. Spouse's Name	
13. Doctor's Name			
14. Doctor's Mailing Address (Street or P.O.Box)			
City	State	Zip Code	

15. Date of Injury (m-d-y) - -	16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/>	17. Date Lost Time Began (m-d-y) - -	
18. Nature of Injury*		19. Part of Body Injured or Exposed*	
20. How and Why Injury/Illness Occurred*			
21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		22. Worksite Location of Injury (stairs, dock, etc.)*	
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site			
Street or P.O. Box		County	
City	State	Zip Code	
24. Cause of Injury(fall, tool, machine, etc.)*			
25. List Witnesses			
26. Return to work date/or expected (m-d-y) - -	27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>	28. Supervisor's Name	29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -	31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/>	32. Length of Service in Current Position Months ____ Years	33. Length of Service in Occupation Months ____ Years
34. Employee Payroll Classification Code		35. Occupation of Injured Worker	
36. Rate of Pay at this Job \$ ____ Hourly \$ ____ Weekly	37. Full Work Week is: ____ Hours ____ Days	38. Last Paycheck was: \$ ____ for ____ Hours or ____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/>

40. Name and Title of Person Completing Form		41. Name of Business	
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ()		43. Business Location (If different from mailing address) Number and Street	
City	State	Zip Code	City State Zip Code
44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code:(6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company		49. Policy Number	

50. Did you request accident prevention services in past 12 months?
YES NO If yes, did you receive them? YES NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X _____ Date _____



Supervisor Accident Report

Report due within 24 hours of accident

Company: _____

Employee/First Name: _____ Last Name: _____

Date of Report _____ Date of Accident/Time _____

Location of Accident _____

Nature of Injuries

Cause of Accident

Were safety devices/equipment used?

Was the employee following proper procedures, directions or training as illustrated in the Safety Manual when the accident occurred?

If employee left work, time of leaving _____

Did employee return to work? Yes (_____) Time _____ No (_____) _____

Name of Physician

If hospitalized, name of hospital

Is there any information regarding the accident that the employer should know?

What actions were undertaken to avoid such future accidents?

Comments: _____

Supervisor Name (Print) _____ Signature _____

(FOR OFFICE USE ONLY)

Employee Accident Report

Company: _____

Employee/ First Name: _____

Last Name: _____

Date of Report _____

Date of Accident/Time _____

Location of Accident _____

Describe details of accident (How, what, where, why) _____

Type of Injury (Cut, bruise, sprain, etc.) _____

Body Location (hand, head, back, etc.) _____

Was special protective equipment provided or required (goggles, special shoes, helmets, etc.)

Yes _____ No _____ If yes, what kind? _____

Was it readily available? Yes _____ No _____ If no, explain. _____

Was such equipment being used or worn at the time of the accident? Yes _____ No _____

If no, why not? _____

Were there any witnesses to the accident? Yes _____ No _____ If yes, please list names.

Witness 1 _____ Witness 2 _____

Witness 3 _____ Witness 4 _____

I, _____ (Employee), the undersigned, certify that the above is a true and correct statement of fact, and that I made such statements of my own free will. I understand that any payments to me or anyone else for expenses in connection with my accident and resulting injury is not an admission of liability on the part of **CCIS**. I authorize full access to copies of medical records, radiology reports, drug/alcohol screenings, and documents of any kind relating to my past or present injury/illness to **CCIS**. I hereby agree to release this information and hold all such medical providers harmless from the release of this information as set forth in this authorization.

Employee Signature

Witnessed by (Signature)

Employee Printed Name

Witnessed by (Printed Name)

Consent For Drug/ Alcohol Screen Testing

I _____ (Name of Applicant), have been fully informed by my potential employer of the reason for this test for drug and/or alcohol. I understand what I am being tested for, the procedure involved, and do hereby freely give my consent. In addition, I understand that the results of this test will be forwarded to Cross Country Infrastructure Services (CCIS) and become part of my record.

If this test result is positive, and for this reason if my pre-employment or my current employment status is affected, I understand that I will be given the opportunity to explain the results of this test.

I hereby authorize these test results to be released to Cross Country Infrastructure Services (CCIS) and/or _____ due to their co-employment agreement.

Applicant Signature Date

Witness Signature Date

(FOR OFFICE USE ONLY)

Reason for testing (Circle One)	Testing Appointment (Date/Time) _____
Pre-Employment	Clinic Name _____
Random	Address _____
Reasonable Cause	City _____ State _____
Accident Investigation	Phone # _____ Fax# _____
Routine	Results Expected back _____

Service To Be Performed (Circle One)

DOT Physical	DOT DRUG Screen	Breath Alcohol
NON-DOT Physical	NON-DOT Drug Screen	Other _____

Comments:

Authorization for Release of Medical Information

Patient: _____

To Whom It May Concern:

You are hereby expressly authorized to release and furnish to Cross Country Infrastructure Services (CCIS) and/or any associate, assistant representative, agent, or employee thereof, any and all desired information (including, but not limited to, office records, medical reports, memos, hospital records, laboratory reports, including results of any and all tests including alcohol and/or drug tests, X-rays, X-ray reports, including copies thereof) pertaining to the physical and/or mental condition which is the basis of my worker's compensation claim. This includes not only current and/or future information, but also all past medical information.

PRINT/ FIRST NAME: _____ LAST NAME: _____

Photo static copies of this signed authorization will be considered as valid as the original.

This is not a release of claims for damages.

DATED: _____ SIGNED: _____

PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT SO THAT WE MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.

Thank you,

Cross Country Infrastructure Services (CCIS)