

Accident Report Form



POST IN A CONSPICUOUS LOCATION

REPORT ALL ACCIDENTS/INJURIES IMMEDIATELY!

Call MatrixOneSource at 866-453-2722

All medical treatment beyond first aid must be preauthorized by MatrixOneSource.

Client Companies must ensure that every injured employee submits to a post accident drug screen at the time of medical treatment. The employee's failure of refusal to submit a drug screen could jeopardize his/her workers' compensation benefits.

- 1. First Aid** - Get injured employee treatment by someone trained in first aid **IMMEDIATELY!**
- 2. Preauthorization and Treatment (When Employee is Not Severely Injured)** - If more than first aid is needed and the injured employee is not severely injured, notify MatrixOneSource immediately for authorization and get the injured employee to the nearest medical clinic or facility for treatment and a post-accident drug screen.
- 3. Emergency Treatment (When Employee is Severely Injured)** - If the injured employee is severely injured, he/she should be taken to the nearest hospital for treatment and a post-accident drug screen and MatrixOneSource should be notified immediately thereafter. **IF YOU ARE NOT SURE IF AN EMPLOYEE IS SEVERELY INJURED, TAKE THE EMPLOYEE TO THE NEAREST HOSPITAL FOR EMERGENCY TREATMENT**
- 4. Supervisor's Report of Accident** - As soon as possible after the injured employee has been given necessary medical treatment and submitted to a post-accident drug screen, his/her supervisor should complete the Supervisor's Report of Accident form and forward it to MatrixOneSource (see information below) within 24 hours of accident occurrence, Supervisors are responsible for obtaining statements from any witnesses to the accident/injury and completing the Witness Report of Accident form. The form may be obtained by calling MatrixOneSource or from the Matrix Source website at www.matrixonesource.com.
- 5. Employee's Report of Accident** - The injured employee must complete an Employee's Report of Accident form and forward it to MatrixOneSource (see information below) within 24 hours of accident occurrence. If the injured employee is unable to complete the accident report due to injury, he/she should call MatrixOneSource within the 24 hour time period (or as soon as possible) to discuss the accident.

Signature of Officer/Owner: _____

Date: _____

Acknowledgement of Available Modified Duty



MatrixOneSource and its client companies desire to provide their employees with the most expedient and highest quality care possible when they are injured at work. As a result, MatrixOneSource and your on-site employer supervisor(s) have developed a program that will allow injured workers to return to work on a modified duty basis by making accommodations on the job for work restrictions.

According to our records, the doctor has advised you that you have been released to modified duty status as of _____ (Insert Date) . This letter serves as notice that modified duty is available as of _____ and that you should report to work on that date at _____(Insert Time) at _____ (Insert Location) for your next job assignment. Please see the attached doctor’s statement outlining your visit and limitations.

Your failure to report for your next assignment at the time and on the date set forth above will be considered an unexcused absence, and you will not be paid for the days missed after that date and time. Failure to contact your supervisor in response to this letter will be considered an unexcused absence and could lead to termination of your workers’ compensation benefits and loss of employment. MatrixOneSource and your supervisor(s) feel a strong commitment to provide gainful employment to injured workers during their recovery period. No matter how much we believe in the program, it is your cooperation that is essential.

If you have any questions or concerns, please call MatrixOneSource at 866-453-2722

I, _____ Accept Decline (Check One) modified duty.

Employee Signature: _____ Date: _____

All limitations on the employee’s activities set forth in the attached doctor’s recommendation will be strictly observed.

Please read this form carefully and check the appropriate box above. You should make and keep a copy of this Acknowledgment for your records.

PLEASE RETURN THE ORIGINAL OF THIS FORM TO:

MATRIXONESOURCE
ATTENTION: RISK MANAGEMENT
9016 Philips Highway
Jacksonville, Florida 32256

Employee's Report of Accident



9016 Philips Highway
Jacksonville, Florida 32256

Please Fax completed form to (904) 262-2760; Attention: Risk Management Dept.

Information

Employee's Name: _____ Age: _____ Sex: _____

Social Security Number: _____ Job Position: _____

Client Company: _____ City: _____

Supervisor's Name: _____

Date and Time of Accident: _____

Location of Accident: _____

Task Being Performed When Accident Occured:

To Whom the Accident Was Reported: _____

Name(s) of Witness(es): _____

Describe How Event Occured:

Part(s) of the Body Injured _____

Describe All Injuries in Detail:

Date and Time you First Sought Medical Attention: _____

Name of Doctor and/or Facility: _____

Please Check the Box That You Feel is Appropriate:
 I require medical treatment and I will undergo a post-accident drug test and release the results to MatrixOncSource and its designated representatives.
 I am refusing both medical treatment and a post-accident drug test. I understand that I may be required to pay ALL costs of my medical treatment if sought in the future.

Employee Name: _____

Employee Signature: _____ Date: _____

Injury Report Checklist



Please Fax completed form to (904) 262-2760
Attention: Risk Management Dept.

Information

Client Company:	Location:
Employee Name:	SSN:
Person Completing Checklist:	Accident Date:

Questions

1. Did you get statements from the injured employee, witness (cs), and supervisor regarding the extent of the injury? (You may wait and follow up later with item 1 if the injury is severe and the employee requires immediate care.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Did you contact MatrixOneSource with information about the accident/injury immediately after the accident? If no, why not?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Was the injured employee taken or directed to a medical provider authorized by MatrixOneSource?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Did anyone accompany the injured employee to the medical treatment facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Was the medical provider informed that MatrixOneSource is the employer of record?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Was the medical provider instructed to mail medical reports, bills, and all documentation to MatrixOneSource?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Was the employee screened for drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Did the injured employee sign the accident/injury report form?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Did you speak with the injured employee after the accident to let him/her know your concern and desire to have him/her back to work as soon as possible?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Did you send copies of information you received from the doctor to MatrixOneSource?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Have you started a file on this accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Has time been lost due to this injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. If the employee declined medical treatment and did not satisfy the drug screening requirements, did he/she sign the proper forms associated with his/her declination of treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Did you obtain all of the names, contact numbers, and statements from the witness(es)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Have you checked the accident area and equipment used to determine if it was user error or equipment failure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Have you taken any measures to prevent this accident from occurring again?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Have you determined whether proper safety rules were followed or in use at the time of accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name of Person Completing Form: _____

Signature of Person Completing Form: _____ Date: _____

Supervisor's Report of Accident



Please Fax completed form to (904) 262-2760
Attention: Risk Management Dept.

Information

Employee's Name: _____ SSN: _____

Client Company: _____ Job Position: _____

Supervisor's Name: _____

Date and Time of Accident: _____

Location: _____

Task Being Performed When Accident Occurred: _____

Date and Time Reported to Management: _____

Name(s) of Witness(es): _____

Describe How Accident Occurred: _____

Accident Resulted in: Injury Fatality

Was First Aid Given? Yes No

If So, By Whom? _____

Where Did Employee Go for Medical Treatment? _____

Who Took the Employee for Medical Treatment? _____

Describe the Injuries in Detail: _____

What Contributed Directly to This Accident? _____

How Could This Accident Have Been Prevented? _____

What Could Be Done to Prevent This In the Future? _____

Employee Name: _____

Employee Signature: _____ Date: _____

Witness Report of Accident



Please Fax completed form to (904) 262-2760
Attention: Risk Management Dept.

Information

Witness Name:

SSN:

Address:

City:

State:

ZIP:

Name of Injured Employee:

Name of Client Company:

Date and Time of Accident:

Location:

What Were You Doing When Accident Occured?

Describe What You Saw:

Describe the Injuries in Detail:

When Was the Supervisor Notified?

By Whom?

Name(s) of Other Witnesses:

Describe All Factors You Believe Contributed to the Accident:

Are You Related to the Injured Employee? Yes No

If Yes, How?

Who Took the Employee for Medical Treatment?

Employee Name: _____

Employee Signature: _____ Date: _____