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 preautorized 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: ____________

@2020 MatrixOneSource

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

 @2020 MatrixOneSource

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: ______________

 @2020 MatrixOneSource

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 cmployce, 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.)	☐ Yes	☐ No
2. Did you contact MatrixOneSource with information about the accident/injury immediately after the accident? If no, why not?	☐ Yes	☐ No
3. Was the injured employee taken or directed to a medical provider authorized by MatrixOneSource?	☐ Yes	☐ No
4. Did anyone accompany the injured employee to the medical treatment facility?	☐ Yes	☐ No
5. Was the medical provider informed that MatrixOneSource is the employer of record?	☐ Yes	☐ No
6. Was the medical provider instructed to mail medical reports, bills, and all documentation to MatrixOneSource?	☐ Yes	☐ No
7. Was the employee screened for drugs?	☐ Yes	☐ No
8. Did the injured employce sign the accident/injury report form?	☐ Yes	☐ 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?	☐ Yes	☐ No
10. Did you send copies of information you received from the doctor to MatrixOncSource?	☐ Yes	☐ No
11. Have you started a file on this accident?	☐ Yes	☐ No
12. Has time been lost due to this injury?	☐ Yes	☐ No
13. If the employee declined medical treatment and did not satisfy the drug screcning requirements, did he/she sign the proper forms associated with his/her declination of treatment?	☐ Yes	☐ No
14. Did you obtain all of the names, contact numbers, and statements from the witness(es)?	☐ Yes	☐ No
15. Have you checked the accident area and equipment used to determine if it was user error or equipment failure?	☐ Yes	☐ No
16. Have you taken any measures to prevent this accident from occurring again?	☐ Yes	☐ No
17. Have you determined whether proper safcty rules were followed or in use at the time of accident?	☐ Yes	☐ No

Name of Person Completing Form: ______________________________

Signature of Person Completing Form: ______________________________ Date: ______________

 @2020 MatrixOneSource

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 Occured:

Date and Time Reported to Management:

Name(s) of Witness(es):

Describe How Accident Occured:

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: ______________

 @2020 MatrixOneSource

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: ______________

 @2020 MatrixOneSource