EMPLOYEE INJURY REPORTING PROCEDURE

STEP 1: IS INJURY LIFE THREATENING/EMERGENCY? Call 911/go to ER if yes.

STEP 2: CALL CLAIM INTO TDY 215-736-5147

STEP 3: SEND EMPLOYEE TO OCCUPATIONAL MEDICINE PHYSICIAN IF POSSIBLE.

REMINDER: YOU MAY OBTAIN A LIST OF MEDICAL PROVIDERS IN YOUR AREA WHICH ARE IN OUR NETWORK - FAILURE TO RECEIVE TREATMENT FOR NON-EMERGENCIES AT A TREATMENT FACILITY COULD RESULT IN PAYMENT BEING DENIED.

***EMPLOYEE BRING THE FOLLOWING WITH YOU TO THE TREATMENT FACILITY:

1) PROTOCOL FOR TREATMENT OF INJURED EMPLOYEES
2) EMPLOYEE MEDICAL RELEASE FORM (FORM C BELOW)

EMPLOYEE MUST SUBMIT TO POST-INJURY DRUG SCREEN AT INITIAL TREATING CLINIC. DRUG SCREEN MUST BE DONE WITHIN 24 HOURS POST–INJURY EVEN IF NO TREATMENT IS RENDERED.
**special note: Post injury drug screens in Georgia only must be completed within 8 hours post-injury*

STEP 4: **FAX THE FOLLOWING INFORMATION TO WORKER'S COMPENSATION DEPARTMENT:** (TDY Fax number 215-839-3442)

A. EMPLOYEE UNINTENTIONAL INJURY REPORT
B. SUPERVISOR UNINTENTIONAL INJURY REPORT
C. EMPLOYEE MEDICAL RELEASE FORM
D. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
E. OASIS WORKERS COMP INJURY WORKSHEET (employee to fill out "General Information" and "Injured Employee Information" only - PRINT LEGIBLY
F. TREATMENT REFUSAL FORM-Complete this form if you do not require medical treatment

TDY TO FAX OR EMAIL TO OASIS AFTER REVIEWING

**special note: California and Oregon must complete an additional state specific form, Procedure may vary in Washington State - Please contact a member of the worker's comp team with any questions*

STEP 5: **EMPLOYEE MEDICAL RELEASE FORM** MUST BE OBTAINED BEFORE EMPLOYEE RETURNS TO WORK. ****ALL MODIFIED DUTY ASSIGNMENTS MUST BE COORDINATED WITH A MEMBER OF THE WORKERS' COMPENSATION DEPARTMENT AND APPROVED BY EMPLOYER.**

REMINDER: ALL QUESTIONS OR ISSUES SHOULD BE DIRECTED TO A MEMBER OF THE WORKER'S COMPENSATION DEPARTMENT AT 1-866-757-7475.
PLEASE PRINT LEGIBLY ON ALL FORMS

TDY MEDICAL STAFFING, INC.
TDY GOVERNMENT SERVICES

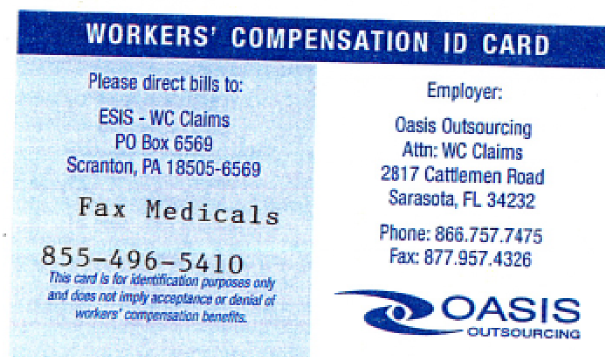
PROTOCOL FOR THE TREATMENT OF INJURED EMPLOYEES

(TDY EMPLOYEE – Bring this form with you to the treatment facility)

Please observe the following protocol as a guideline for all employees of TDY seeking medical care at your facility for an on-the job injury or illness.

- **Medical Emergencies:** Any medical emergency should be treated at the nearest emergency department or call 911. Non-emergenices must be treated in accordance with our policy to be covered by the insurance carrier.
- **Over-the-Counter Medicine:** If the extent of the injury or illness allows for non-prescription medicine, please direct the employee to use over-the-counter medicine.
- **Medical Release:** **TDY** must obtain a medical release statement from the treating physician in order to return the employee back to work; either Full Duty or Light Duty (if applicable).
- **Insurance Carrier:** Please contact the number on the card below for information concerning insurance carriers / approved clinics for treatment.
- **Billing:** Forward all bills for medical treatment and drug screens associated with Worker Compensation to the address on the card below.
- **Additional:** TDY employees are covered by a workers comp policy provided by a PEO (co-employer) Oasis. Questions for Oasis can be directed to 1-866-757-7475.

The insurance card below is to be used only for issues directly related to a reported workplace injury. DO NOT ATTEMPT TO USE THIS CARD FOR ANY OTHER PURPOSE. Direct any questions to the number on the card.



TDY MEDICAL STAFFING, INC.
TDY GOVERNMENT SERVICES

A

EMPLOYEE INJURY INCIDENT REPORT

Each employee is required to complete this form after experiencing an unintentional work related injury. This form is used as official documentation that an on-the-job injury has occurred. Please be as specific as possible when completing this form. PLEASE PRINT CLEARLY **and fax to 215-839-3442 when completed**.

EMPLOYEE INFORMATION:

Employee Name	Complete Mailing Address (No P.O. Box)	Home Telephone Number	
Social Security Number	Job Title	Date of Birth	Marital Status

THE LAW PROVIDES FOR SEVERE PENALTIES IF YOU WITHHOLD A MATERIAL FACT OR MAKE A FALSE STATEMENT ON THIS OR ANY OTHER FORM TO OBTAIN WORKERS' COMPENSATION BENEFITS.

INCIDENT INFORMATION:

Date Injury Occurred	Time of Day Injury Occurred	TDY Client Name
Address Where Injury Occurred	What was the Injury?	Date Returned To Work

INCIDENCE OCCURRENCE:

How did the injury occur? (*Describe fully the events, which resulted in this injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors, which led or contributed to this claimed injury or disease.*)

Were any safeguards provided? Used? *If so, please explain*:

Did you report this incident to anyo ne at the Client? *If so, to whom and when did you report it?*	Did anyone witness this incident? *If so, please list names:*
Did you notify anyone at TDY about this incident? *If so, to whom and when did you notify?*	

MEDICAL INFORMATION:	**NOTIFICATION OF ABILITY TO WORK:**
Do/Did you require medical attention? (*Please explain. Name the doctor, clinic, address and phone number of facility you will see/were seen.)* Was a Drug Screen performed? Y or N, *If not, why*? Date and Time of Next Doctor's Appointment?	Did the Doctor report you could return to work? Y or N *If Yes, was it (circle one) FULL DUTIES or RESTRICTED DUTIES* If RESTRICTED, List your restrictions: Have you returned to work? Y or N If No, please explain:

I hereby certify that the above statements are true to the best of my knowledge or belief. I am aware that the law provides for severe penalties if I knowingly and/or with fraudulent intent withhold a material fact of make a false statement on this or any other form in order to obtain workers' compensation benefits. Additionally, I understand that TDY requests that I keep them apprised of my medical/work status at all times. I further understand that TDY offers modified-duty assignments to employees based on prescribed medical limitations resulting from job related injuries. I agree to contact TDY's Worker's Compensation Department at 904.253.3134 to comply with this request.

Employee Signature: **Date**:

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TDY GOVERNMENT SERVICES

B

SUPERVISOR'S NOTICE OF INJURY

Please complete this form after a TDY Medical Staffing employee becomes injured due to on-the-job activities. Write N/A (not applicable) for those that do not apply. PLEASE PRINT CLEARLY and fax to 215-839-3442 when completed.

EMPLOYEE INFORMATION:

Employee Name	Sex	Address
	Male or Female	

Time shift began:	Did employee leave work? *If so, when?*	Has employee returned to work? *If so, when?*	Did employee miss a regularly scheduled shift? Yes or No

TDY Office Representative:

INCIDENT INFORMATION:

Date Injury Occurred	Time of Day Injury Occurred	Client Name
Address Where Injury Occurred	What was the Injury?	Date Returned To Work

INCIDENCE OCCURRENCE:

How did the injury occur? (*Describe fully the events that resulted in this injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors that led or contributed to this claimed injury or disease.*) Were any safeguards provided? Used? *If so, please explain*:

Did this employee report this incident to anyone at the work site? *If so, to whom and when?*	Did anyone witness this incident? *If so, please list names:*
Did you notify anyone at TDY about this incident? *If so, to whom and when?*	Did employee require medical attention? (*Please explain.*)

Do you agree with the description of this incident? *Is no, please explain in detail.*	What corrective actions are required to prevent a reoccurrence of the injury? (*Immediate actions*) ____ (*Future actions*)

____

Print Supervisor Name: Supervisor's Signature: Date:

TDY MEDICAL STAFFING, INC.
TDY GOVERNMENT SERVICES

C

EMPLOYEE MEDICAL RELEASE FORM

(TDY EMPLOYEE – Bring this form with you to the treatment facility)

Following treatment of this employee, please complete this form and forward a copy to The Worker's Compensation Department at FAX # 215-839-3442

IDENTIFYING INFORMATION

Injured Employee Name ____________________
Soc. Security No. ____________________

Name of Physician/Clinic ____________________
Address ____________________
City/State/Zip ____________________
Telephone ____________________

TO BE COMPLETED BY THE PHYSICIAN:

Please check the appropriate condition(s) of the employee:

DIAGNOSIS:____________________

WORK STATUS:

ž Instructed to return to work with no limitations on (date)____________________.

ž Off of work. Estimated period of temporary disability:____________days.

ž Off of work the balance of this shift only.

ž Return to Modified Work with the following capabilities/limitations:

- Limited pushing/pulling:___________
- Limited lifting/carrying:_________lb.
- Limited twisting:________________
- Limited kneeling:________________
- Limited use of _____arm/hand:_____
- No ladders/platforms/scaffolds.
- Keep cast/dressing clean & dry:____________
- Limited stooping/squatting/bending:________
- Limited walking/standing:________________
- Limited continuous sitting:________________
- No work with hazardous machinery or mobile equipment.
- Avoid exposure to:____________________

- Light office/clerical duties only.

FUTURE MEDICAL TREATMENT:

Return Visit Scheduled On:______/____/______

Physical Therapy On:__________/____/______

____
Physician Name/Signature/Date

TDY MEDICAL STAFFING, INC.
TDY GOVERNMENT SERVICES

D

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO ALL PROVIDERS

PATIENT NAME: ____

SOCIAL SECURITY NO: ____

DATE OF BIRTH: ____

DATE OF INJURY: ____

I GIVE PERMISSION TO MY PHYSICIANS OR OTHER HEALTH CARE PROVIDERS, HOSPITALS, OR CLINICS TO RELEASE MY MEDICAL RECORDS RELATING TO THIS INJURY/ILLNESS TO TDY MEDICAL STAFFING, ITS DIVISIONS OR ITS AGENTS. THIS INCLUDES, BUT NOT LIMITED TO, HISTORY, FINDINGS, OFFICE AND PATIENT CHARTS, EXAMINATION AND PROGRESS NOTES, X-RAYS AND DIAGNOSTIC TEST RESULTS. I UNDERSTAND THAT THIS INFORMATION WILL BE USED TO ASSIST MY EMPLOYER IN EVALUATING MY INJURY/ILLNESS AND MY WORK STATUS.

SIGNED: ____
PATIENT
DATE: ____

PROVIDER: PLEASE MAIL OR FAX CORRESPONDENCE TO:

TDY Medical Workers Compensation:

FAX: 215-839-3442

TREATING MEDICAL CLINIC NAME:____

LOCATION:____

PHONE:____

Submit by Email | Print Form

E

Workers' Compensation Injury Worksheet

Immediately email completed form and work status to ESIS_FNOL@firstnotice.com

or contact us at 866-757-RISK (7475).

General Information			
Today's Date:	Time:	Employee's Supervisor:	
Company Information			
Client Name: TDY Medical	Client ID: 8438	Address (Street, City, State & Zip): PO Box 261, Yardley, PA 19067	
Phone Number: 215-736-5147			
Injured Employee Information			
Name (First, Middle, Last):		Date of Birth:	Date of Hire:
Social Security Number:		Physical Description (Height, Weight, Hair color etc.):	
Home Phone Number:			
Cell Phone Number:			
Employee Address (Street, City, State & Zip):			
Accident Information			
Date of Accident:	Time:	Was the accident on premises? ☐ Yes ☐ No If not, where?	Was there a safety device in use? ☐ Yes ☐ No Explain?
Description of Accident:			
Were there witnesses? ☐ Yes ☐ No If Yes, please list below: 1. 2. 3.		Description of the injured body part? ☐ Left ☐ Right	
Other Information			
Do you agree with the accident explanation? ☐ Yes ☐ No		Drug free workplace? ☐ Yes ☐ No	
Drug test completed? ☐ Yes ☐ No		Treating Facility:	
Do you have knowledge of any preexisting conditions, prior accidents or current medical treatment which may have been a factor in this incident or injury? ☐ Yes ☐ No Explain:		Treating Facility Address (Street, City, State & Zip):	
Company Contact Name**:		Company Contact Phone Number:	
Return to Work Information			
Has the employee returned to work? ☐ Yes ☐ No If Yes, when? If No, last date worked?		When was the last work day that was paid in full?	Occupation: Modified or Light Duty Available: ☐ Yes ☐ No
Email Signature			
Any person who, knowingly and with intent to injure, defraud or deceive any employer, employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony. I have reviewed, understand and acknowledge the above statement.			
Supervisor Email:		Employee Email:	

*This form is for reporting purposes only. It is not valid as authorization for medical treatment.
**The contact person should be the one the insurance carrier and Oasis can call for information.

F

TREATMENT REFUSAL FORM

(To be completed by employee)

Employee Name: ____

Date of Injury: ____

Part of Body: ____

Description of Accident: ____

____

I understand that I am entitled to medical treatment paid for by Oasis Outsourcing for my work related accident. This is to confirm that ________________ offered me medical care as a result of the accident that occurred on____________. I understand that in order to receive medical attention I am required to go to an approved medical provider and obtain authorization from Oasis or their servicing agent prior to receiving medical treatment. By failing to obtain prior authorization before receiving treatment the medical treatment will not be paid for by Oasis Outsourcing. HAVING BEEN SO ADVISED I HAVE ELECTED TO DECLINE MEDICAL TREATMENT FOR THIS INJURY.

Reason for declining medical treatment: ____

____

______________________________ ______________

Employee Printed Name Date

______________________________ ______________

Employee Signature Date