Strategic Focus Clear Vision. Defined Strategy. Proven Results.	**WORKERS' COMPENSATION CLAIM REPORTING CHECKLIST**	3540 E. Broad St. Store 6870 #126 Mansfield, Tx 76063 Phone 214-888-6776 Fax: 1 214 833 7257 Email: claims@stratfocusllc.com

All claims should be reported to Strategic Focus PEO within 24 hours and a drug test is required within 24 hours of all reported incidents.

IF AN EMPLOYEE IS INJURED ON THE JOB, FOLLOW THE STEPS BELOW TO REPORT A CLAIM:

☐ EMPLOYER to Complete the **EMPLOYER INCIDENT REPORT**

☐ EMPLOYEE to Complete the **EMPLOYEE INCIDENT REPORT**

For Medical Treatment – Please complete/provide the following:

☐ Provide Employee with **Authorization for Medical Treatment & Release for Medical Records** Form to complete/sign. *(Employee takes COPY of form to doctor)*

☐ Locate your **Medical Provider List** or **Panel of Physicians** to locate a Medical Provider

☐ Provide Employee with a copy of the **Temporary Prescription Card**

☐ If Employee REFUSES Medical Treatment, have the employee complete and sign the **REFUSAL OF MEDICAL TREATMENT FORM**

Post-Accident Drug Test

☐ Employee Sent for the REQUIRED Post-Accident Drug Test

**Employee must adhere to a mandatory drug screen even if no medical treatment is required.*

If this was an Auto Accident – Please complete/provide the following:

☐ Completed **Auto Accident Report Form**

☐ Copy of the Driver Information Exchange, Statements and a Police Report if available

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E-Mail All Completed Reports To: claims@stratfocusllc.com

If you have any questions, please contact the Strategic Focus HR Coordinator at (214) 888-6776

Strategic Focus Clear Vision. Defined Strategy. Proven Results.	**EMPLOYER INCIDENT REPORT**	3540 E. Broad St. Store 6870 #126 Mansfield, Tx 76063 Phone 214-888-6776 Fax: 1 214 833 7257 Email: claims@stratfocusllc.com

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D THIS FORM TO BE COMPLETED BY THE EMPLOYER

EMPLOYER NAME/CLIENT ID: _____

Employer Contact Phone and email address: _____

INJURED WORKER INFORMATION

Name:		
Date of Birth:	SS#: (Last 4 digits)	Date of Hire:
Address:		City:
State:	Zip:	Phone #:
Job Title:		☐Full Time ☐Part Time ☐Seasonal
How many days per week does the employee work? _____ **From**_____☐AM ☐PM **to**_____☐AM ☐PM		Scheduled Days Off ☐M ☐T ☐W ☐TH ☐FRI ☐SAT ☐SUN ☐Rotating
Was the employee hired to work 40 hours per week? ☐Yes ☐No		If no, for how many hours a week was the employee hired?
Last date of work after incident:		Start time of shift on date of incident: _____ ☐AM ☐PM

DETAILS OF INCIDENT

Date of incident:	Time of incident:_____☐AM ☐PM
Location of incident (include address if different from employer address):	
Describe how and why incident/injury occurred:	
Part(s) of the body impacted: *(Be Specific, e.g., left eye, right forearm, right hand, left lower back)*	
Type of Injury/Illness: *(Be Specific, e.g., cut, bruise, needlestick, strain, burn)*	

Incident Reported to:	Date reported:	Time reported: ☐AM ☐PM
Witnesses? ☐Yes ☐No If Yes, list witnesses:		

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EMPLOYER INCIDENT REPORT CONTINUED

Did injured worker require medical treatment? ☐Yes ☐No ☐First Aid

Name of Doctor/Hospital/Clinic *(if applicable)*:	Address of Doctor/Hospital/Clinic:
First Date of Medical Treatment:	Phone #:
Returned to work? ☐Yes ☐No If Yes, Date Returned to Work: _____ ☐Full Duty ☐Light Duty	Paid for day of incident/injury? ☐Yes ☐No Anticipated Return to Work Date?

Drug Tested? ☐Yes ☐No

If Yes, Date & Time:

Is there any reason to question the validity of claim? ☐Yes ☐No	Is employer aware of any pre-existing conditions? ☐Yes ☐No
Was there any other person/piece of equipment that may have been the cause of the incident/injury? ☐Yes ☐No	Were any safety rules violated? ☐Yes ☐No

Please provide any other information, observations or details about employee and/or incident that may be important for us to know:

REPORT PREPARED BY:	**SIGNATURE:**	**DATE:**

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D THIS FORM TO BE COMPLETED BY THE EMPLOYEE

Your Name:	Phone #:
Job title:	Your Supervisor:
Person you reported the injury to:	
Date you REPORTED the injury:	Time you REPORTED the injury: ☐AM ☐PM

DETAILS OF INCIDENT

Date of incident:	Time of incident:_____☐AM ☐PM
Where did the incident occur (location)?	
Describe in detail how the injury occurred, including object, material or substance that injured you:	
Part(s) of the body impacted: *(Be Specific, e.g., left eye, right forearm, right hand, left lower back)*	
Type of Injury/Illness: *(Be Specific, e.g., cut, bruise, needlestick, strain, burn)*	
Have you injured this part(s) of your body before? ☐Yes ☐No *If Yes, please provide detail below:*	

Date	**Description (Body part/area affected)**	**Treating Physician**

What could you have done to prevent this injury? *(e.g. more training, wear non-slip shoes, protective gloves or eyewear)*

Name of Doctor/Hospital/Clinic	Address:
First date of medical treatment:	Phone #:

Any person who, knowingly and with intent to injure, defraud, or deceive any employer, employee or insurance company, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree. I have reviewed, understand and acknowledge the above statement.

EMPLOYEE SIGNATURE:	**DATE:**

Strategic Focus Clear Vision. Defined Strategy. Proven Results.	**AUTHORIZATION FOR MEDICAL TREATMENT & RELEASE FOR MEDICAL RECORDS**	3540 E. Broad St. Store 6870 #126 Mansfield, Tx 76063 Phone 214-888-6776 Fax: 1 214 833 7257 Email: claims@stratfocusllc.com

Email the completed forms to claims@stratfocusllc.com FAX (214) 833-7257

D THIS FORM TO BE COMPLETED BY THE EMPLOYEE & COPY taken to the Medical Provider

MEDICAL TREATMENT AUTHORIZATION

EMPLOYEE NAME:	**DATE OF INCIDENT:**
This is authorization for initial medical treatment arising from a job-related injury being reported under Workers' Compensation.	**All billing and authorizations should be directed to Strategic Focus PEO:** Strategic Focus PEO Texas Mutual Claims: PO Box 12029 Austin, Texas 78711 Healthcare: 888-532-5246
NOTE: DRUG SCREEN REQUIRMENT: **A 10-panel drug screen is required on all work-related injuries.**	

MEDICAL TREATMENT AUTHORIZED BY STRATEGIC FOCUS PEO: Kristin Battle

AUTHORIZATION FOR MEDICAL RECORDS AND COMMUNICATION RELEASE

I hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of my mental or physical health, history, condition or well-being, to supply such information to my employer or its insurance carrier, claims administrator or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer or its insurance company, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment, and as to any other issues including diagnosis, prognosis, causal connection of care and treatment to my work injury or duties, and ability to work. I hereby waive my physician-patient privilege. In conjunction with this, I also authorize any treating physician or medical provider to review any additional materials provided to them.

A photocopy of this authorization shall be as valid as the original. This release shall remain valid for the length of my claim.

Note: Workers' Compensation Requests Are Exempt From HIPAA. Pursuant to 45 CFR, Sect. 164.512(1) a covered entity may without penalty under HIPAA disclose protected health information to the extent necessary to comply with the law relating to workers' compensation.

EMPLOYEE NAME ***(PLEASE PRINT)*****:**	**DATE OF BIRTH:**
EMPLOYEE SIGNATURE:	**DATE:**

Strategic Focus Clear Vision. Defined Strategy. Proven Results.	**REFUSAL OF MEDICAL TREATMENT**	3540 E. Broad St. Store 6870 #126 Mansfield, Tx 76063 Phone 214-888-6776 Fax: 1 214 833 7257 Email: claims@stratfocusllc.com

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ACKNOWLEDGEMENT OF REFUSAL OF MEDICAL TREATMENT

I,_____, acknowledge that I have refused to be medically evaluated for a work related injury I sustained on_____. I understand that by signing this document any future claims regarding this injury will require me to notify my supervisor immediately. I also understand that even though I do not require medical treatment for this injury, I still must adhere to a mandatory drug screen.

EMPLOYEE NAME *(PLEASE PRINT)*:	
EMPLOYEE SIGNATURE:	**DATE:**
EMPLOYER SIGNATURE:	**DATE:**

Strategic Focus Clear Vision. Defined Strategy. Proven Results.	**REFUSAL OF POST-ACCIDENT DRUG TEST**	3540 E. Broad St. Store 6870 #126 Mansfield, Tx 76063 Phone 214-888-6776 Fax: 1 214 833 7257 Email: claims@stratfocusllc.com

Email the completed forms to claims@stratfocusllc.com **FAX (214) 833-7257**

ACKNOWLEDGEMENT OF REFUSAL TO SUBMIT TO POST-ACCIDENT DRUG TEST

I,_____, acknowledge that I have refused to submit to a post-accident drug test as required by my employer. I understand that refusing to submit to a post-accident drug test may lead to disciplinary action up to and including termination and may result in a loss of workers' compensation and/or unemployment compensation benefits.

EMPLOYEE NAME ***(PLEASE PRINT)*****:**	
EMPLOYEE SIGNATURE:	**DATE:**
EMPLOYER SIGNATURE:	**DATE:**