



Injury and/or Incident Report Process For Reporting On the Job Injuries or Incidents

- **Employee’s Injury/Incident Report Form**
This form is to be filled out by the injured employee and reviewed and signed by the supervisor.
- **Notice Regarding Workers’ Compensation Benefits**
This notice is to be given to the injured employee.
- **Supervisor’s Injury/Incident Investigation Report**
This form is to be filled out by the injured employee’s supervisor. Please answer all questions completely and with detail, do not put NA, unavoidable, etc.
- **The supervisor is responsible for faxing all forms to Human Resources within 24 hours from the time of injury. The Confidential FAX Number: (623) 773-5163. Originals must be forwarded to Human Resources.**
- **Employer’s Authorization For Examination or Treatment**
This notice is to be signed by a supervisor and given to the employee REGARDLESS of whether or not they seek treatment. If the employee is subject to Post Accident Drug Testing please complete the appropriate boxes on the authorization form.

Authorized Treatment Locations:

	Banner Thunderbird Clinic	Banner Estrella Clinic	Banner Good Samaritan Clinic
Hours	Monday – Friday 7:00 a.m. – 6:00 p.m.	Monday – Friday 7:00 a.m. – 6:00 p.m.	Monday – Friday 6:00 a.m. – 10:00 p.m. Saturday – Sunday 8:00 a.m. – 4:00 p.m.
Address	5601 W. Eugie Ave. Ste 213 Glendale, AZ 85305	9305 W. Thomas Rd. Ste 235 Phoenix, AZ 85307	1300 N. 12 th St. Ste 250 Phoenix, AZ
Telephone	602-865-5618	623-327-4100	602-839-4456
Important Information			Clinic will validate parking Park on Level 4 after 5:00 p.m. on weekends

For Emergency or After-Hours Treatment Go to the Nearest Emergency Room

Effective 5/1/2015 – Worker’s Compensation Benefits & Claims Administrator:

Tristar Risk Management
1430 E Missouri Ave., Ste. #B267
Phoenix, AZ 85014
Phone: 602-331-3511
Fax: 602-997-6804
Policy Number: City of Peoria

Any questions please contact Human Resources (623) 773-7100.



CITY OF PEORIA
EMPLOYEE'S INJURY/INCIDENT REPORT
(To be completed by the Employee)

FAX to: 623-773-5163

Employee Name: _____ Employee ID No: _____

Employee Address: _____ City: _____ Zip: _____

Employee Phone No.:(_____) _____ Supervisor's Name: _____

Date of Birth: _____ Marital Status: _____ Sex: Male Female

Job Title: _____ Length of time in position: _____

Hours worked per day: Start Time: _____ am pm End time: _____ am pm

Number of Work Days worked per week: _____

Are you engaged in any other type of work or employment? Yes No

(If "yes" on a separate sheet state the name and addresses of employers, type of work, position and date last worked)

Accident/Incident Date: _____ Time: _____ am pm

Accident Location: _____

Name specific area(s) of body injured: _____

Explain in your own words what happened, making certain to name tools or equipment being used (If City vehicle or property was involved, include vehicle number and damage): _____

Were you performing regularly assigned duties? Yes No

If not, have you done this type of work before? Yes No

Did you receive clear and proper instructions/training on how to perform the work that you were doing? Yes No

Did you seek medical attention? Yes No

First aid administered by: _____

If referred, name of doctor/hospital: _____

Can you continue your regularly assigned duties: Yes No

If not, last day worked: _____ Expected return date: _____

Witness(s) to accident/injury (Include address and telephone number): _____

Was another person responsible for your injury or illness? If so, name, address, telephone number, description and license plate of vehicle (if any), and insurance company information: _____

****If a Police Report was prepared please provide a copy****

Recommendations to prevent similar accident: _____

EMPLOYEE'S STATEMENT: I certify that all statements in this report are true, and I agree and understand that any misstatement or omission of material fact herein may constitute cause for disciplinary action up to and including termination. I have received a copy of the "Notice Regarding Workers' Compensation Benefits" form. I authorize the release of medical information regarding this injury or illness to representatives of my employer.

Employee Name (Please Print)

Employee Signature

Date Signed

SUPERVISOR'S STATEMENT: I certify that I have thoroughly investigated this incident and that the information as reported is complete and correct. If not, attach sheet with explanation.

Supervisor Name (Please Print)

Supervisor Signature

Date Signed

PROVIDE A COPY OF THIS NOTICE TO THE EMPLOYEE AT THE TIME OF INJURY

**NOTICE REGARDING WORKERS' COMPENSATION BENEFITS
WORKERS' COMPENSATION BENEFITS AND CLAIMS ARE ADMINISTERED BY:**

**Tristar Risk Management
1430 E Missouri Ave, Ste #B267
Phoenix, AZ 85014
Phone: 602-331-3511
Fax: 602-997-6804
Policy #: City of Peoria**

Employees are to report any accidents **immediately** to their supervisor. The Supervisor will assist in filling out a report of injury. Any delay in reporting may delay workers' compensation benefits.

IN CASE OF INJURY

1. Initial Medical Care / Reporting Injury

- FOR A SERIOUS INJURY, CALL 911
- The injured employee is to be taken to the authorized medical facility or to an emergency room, if necessary.

Authorized Facilities:

	Banner Thunderbird Clinic	Banner Estrella Clinic	Banner Good Samaritan Clinic
Hours	Monday – Friday 7:00 a.m. – 6:00 p.m.	Monday – Friday 7:00 a.m. – 6:00 p.m.	Monday – Friday, 6:00 am – 10:00 pm Saturday – Sunday, 8:00 am – 4:00 pm
Address	5601 W. Eugie Ave., Ste 213 Glendale, AZ 85305	9305 W. Thomas Rd., Ste 235 Phoenix, AZ 85307	1300 N. 12 th St., Ste 250 Phoenix, AZ
Telephone	602-865-5618	623-327-4100	602-839-4456
Important Information			Clinic will validate parking Park on Level 4 after 5:00 p.m. on weekends

IMPORTANT: After Hours Post Accident Drug & Alcohol Testing: If you are subject to Post Accident testing after Banner Occupational Health is closed, report to Concentra at the following location:

Concentra Airport Phoenix (24/7 availability)
1818 E Sky Harbor Circle North
Building 2, Ste 150
Phoenix, AZ 85034
Phone: 602-244-9500 Fax: 602-244-9543

2. Follow Up Care / Reporting Progress To Supervisor And Human Resources

Certain employees may be entitled to benefits when they are injured or become ill because of their jobs. These benefits include:

- **Medical Care** – All authorized medical expenses are fully covered for approved claims. If you need medical care, please go to the authorized medical facility listed above. If you have any questions about medical care visits, or changes in appointments please your claims adjuster.
- **Reporting Medical Progress** – You must keep your Supervisor and Human Resources informed about all visits to the physician. You are required to bring documentation of your visits to the physician within 24 hours of the visit into the HR Department.
- **Light Duty** – If you are released to light duty, the release must be presented to the Human Resources Department prior to performing any duties. The HR Department will coordinate all "Light Duty" assignments with the department. HR will advise your department of the work restrictions and be advised if there is light duty work available. If so your department will contact you with the light duty assignment details. You must wait for contact from your department or HR before returning to work. You may be required to perform duties outside of your normally assigned department or work station. Please note that any light duty restrictions and/or instructions from the health care provider must be adhered to during work and non-work hours.
- **No Work Status/Off Duty** – If you are required by the physician to be on a "No Work Status/Off Duty," you must immediately present a written update from your physician to the Human Resources Department following each visit. Please note that any light duty restrictions and/or instructions from the health care provider must be adhered to during work and non-work hours.
- **Return To Full Duty** – When the physician releases you for full duty, the release must be presented to your Human Resources Department immediately and prior to your performance of any normally assigned duties.

NOTE – For those employees who work during hours that the Human Resources Department is not available, any change in work status should be communicated to your Supervisor and the notes should be forwarded to HR. HR will then confirm the work status with the department on the next working day.

The third party administrator will investigate and prosecute any fraudulent claims, which may result in an order for restitution and possible imprisonment. Fraudulent claims may result in discipline, up to and including termination.



CITY OF PEORIA
SUPERVISOR'S INJURY/INCIDENT INVESTIGATION REPORT
(To be completed by the employee's Supervisor)

FAX: 623-773-5163

Employee Name: _____ Employee ID No.: _____

Department: _____ Division: _____

Accident/Incident Date: _____ Time: _____ am pm

Accident Location: _____

Name specific area(s) of body injured: _____

Explain in your own words what the employee was doing at the time of injury and how the accident occurred:

If City vehicle or property was involved, include vehicle number and damage: _____

Was the employee performing regularly assigned duties? Yes No

If not, has employee done this type of work before? Yes No

Did employee receive clear and proper instructions/training on equipment operation and safety precautions? Yes No

Was the job hazard analysis (JHA) reviewed with the employee? Yes No

If so, Date the JHA was Reviewed: _____

Was the job hazard analysis (JHA) followed? Yes No

If "No" why? _____

Did employee seek medical attention? Yes No

First aid administered by: _____

If referred, name of doctor/hospital: _____

Can employee continue their regularly assigned duties: Yes No

If not, last day worked: _____ Expected return date: _____

Witness(s) to accident/injury: _____

Was another person responsible for employee's injury or illness? If so, name/address: _____

Recommendations to prevent similar accident: _____

Recommendations regarding mechanical deficiencies / environmental concerns: _____

SUPERVISOR'S STATEMENT: I certify that I have thoroughly investigated this incident and that the information as reported is complete and correct.

 Supervisors Name (Please Print)

 Supervisors Signature

 Date Signed

 Managers Signature (Please Print)

 Managers Signature

 Date Signed

 Department Directors (Please Print)

 Department Directors Signature

 Date Signed



City of Peoria

EMPLOYER'S AUTHORIZATION FORM FOR MEDICAL EXAMINATIONS, DRUG SCREENINGS, AND TREATMENT



Banner Occupational
Health Services

- Instructions:**
- 1.) Complete the form including Patient/Employee information, type of service and authorization.
 - 2.) Send a copy of the completed form to HR by email or interoffice mail Attn: Beth Ullinger
 - 3.) Give the original to the employee to take to Banner.

(Must present photo ID at time of service)

Patient/Employee Name: _____	Employee ID# (if applicable): _____
Dept. #: _____ Dept. Name: _____	Job Title: _____
Banner Location:	Appointment Date/Time: _____

Banner Estrella: fax 623-327-4170
 Banner Thunderbird: fax 602-865-5651
 Banner Good Samaritan: fax 602-839-3182
 Other: _____
 (See reverse side for clinic locations.)

CDL Exam (Renewal)	<input type="checkbox"/> CDL Medical Exam
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Reasonable Suspicion	<input type="checkbox"/> Drug & Alcohol Test (12 Panel)
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Post Accident/Workers' Compensation	Date of Incident: _____ <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Exposure <input type="checkbox"/> Drug & Alcohol Test <input type="checkbox"/> Other
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Vaccinations	<input type="checkbox"/> Hep B <input type="checkbox"/> Titer
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Referring Supervisor Authorization *(Required for CDL, Reasonable Suspicion, Post Accident, Workers Comp & Vaccinations)*

Authorized by: (Printed name)	Title:	Signature/Date:	Phone:
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Pre-Employment Exam & Drug Testing	<input type="checkbox"/> 5 Panel Rapid Only <input type="checkbox"/> Pre-Employment Physical & 5 Panel Rapid <input type="checkbox"/> Pre-Employment Physical, CDL Medical Certification & DOT FTA Drug Screen <input type="checkbox"/> Pre-Employment Physical, CDL Medical Certification & DOT FMCSA Drug Screen
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Random Selection	<input type="checkbox"/> FTA Random Drug Test	City of Peoria		Banner	
	<input type="checkbox"/> FTA Random Alcohol Test	DATE	TIME	DATE	TIME
	<input type="checkbox"/> FMCSA Random Drug Test	DEPARTMENT NOTIFICATION		CHECK IN	
<input type="checkbox"/> FMCSA Random Alcohol Test			VERIFIED BY		

Banner – Once Random Section is completed, please fax to 623-773-5163

Human Resources Authorization *(Required for Pre Employments Exams & Random Selection Drug Screens)*

Authorized by:	Title:	Signature/Date:	Phone:
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Reporting Results

<input type="checkbox"/> Fax: 623-773-7140 (Pre-Employment, Reasonable Suspicion) Contact: Claudia Hasbrouck 623-773-5149 Maryann Loya 623-773-7952	<input type="checkbox"/> Fax: 623-773-5163 (CDL, Post Accident, Random Selection) Contact: Kristen Venditte 623-773-5159 Leona Vela 623-773-7554
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City of Peoria (HR Use Only)	Invoice Dt:	Invoice #:	Total Charge:	COP Check Req#/Date:	Processed by:
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