

# ProSource

## Management Solutions

**TO: MANAGERS, ON SITE ADMINISTRATORS, OR SUPERVISORS RESPONSIBLE FOR RESPONDING TO ON THE JOB INJURIES.**

### **POLICY STATEMENT:**

It is Company policy to provide any employee who is injured on the job with proper medical treatment, and to return him or her back to work as soon as possible. If an employee misses time away from work due to an on the job injury, it is important to sustain regular communication with the employee.

### **PROCEDURE:**

When an employee is injured on the job, he or she should report the injury immediately to their Manager, On-site Administrator, or Supervisor. If the injury is minor, such as a small cut or abrasion, the individual can be immediately treated with physician approved First Aid supplies. However, ProSource still requires an incident report.

- 1) **Life Threatening Injuries:** If the injury is very serious, the injured employee should not be moved and an ambulance should be called. A supervisor should follow the employee to the medical facility and contact ProSource immediately upon arrival.
- 2) **Non-life Threatening Injuries:** If the injury does not require an ambulance, the supervisor should contact ProSource and provide information regarding the injury. (If this is not possible, the supervisor should contact ProSource immediately upon arrival at a Texas Mutual Insurance Company's approved network medical provider or facility.) **PLEASE SEE THE TEXAS STAR NETWORK, EMPLOYEE NOTICE OF NETWORK REQUIREMENTS. Network doctors have agreed to look to Texas Mutual Insurance Company for payment of work related injuries. If an employee obtains care from a doctor who IS NOT IN THE NETWORK without prior approval from Texas Star Network, the employee may have to pay for the cost of that care.** An employee may access non-network health care providers and still be eligible for coverage of medical costs if one of the covered exceptions applies. See the information packet. At time of injury, the employee **MUST BE GIVEN** a copy of the **THE TEXAS STAR NETWORK, EMPLOYEE NOTICE OF NETWORK REQUIREMENTS**. The employee is to retain pages 1-8 for their records, and sign and return to you page 9. The signed acknowledgement form should be submitted to ProSource with your Employer's First Report of Injury.

**Ambulance service should never be used as a simple form of transportation in non-emergency situations.**

The employee's Manager, On-site administrator, or Supervisor must complete the **Employer's First Report of Injury and fax it to our office within 24 hours of the accident.** In addition to the First Report, and to assist ProSource in analyzing the circumstances that led to the accident, we also request that an Employee Statement, Witness Statement, and Supervisor Statement be completed and returned to ProSource whenever requested.

**Any employee treated for an on-the-job injury will receive a mandatory drug/alcohol test as part of their treatment. Any employee who refuses to take the mandatory drug/alcohol test will be considered to have voluntarily resigned his/her employment, since taking the test is required for all on-the-job injuries and is a condition of employment as stated in the Rules of Conduct in the Employee New Hire Packet and in the Employee Handbook.**

Based on the diagnosis and return-to-work status provided by the treating physician, if the injury employee cannot be released for "Full Duty", a "Light Duty" position should be made available in order to return the employee to work as soon as possible. In the event the employee cannot be returned to work for a period of time, the Manager, On-site administrator, or Supervisor should establish a method of communicating with the employee on a regular basis, such as weekly telephone calls to find out how the employee is convalescing. ProSource should be notified immediately when the employee returns to work, either light duty or full duty. The payroll department may not be aware that a claim is in progress, **therefore turning in hours is not sufficient notification for return to work status.**

To report an accident after normal business hours, please call the ProSource representative at (713) 667-3690 or Texas toll free (888) 667-3690. Accident forms should be faxed to ProSource at (713) 660-3629 or Texas toll free (866) 660-3629. Inability to reach a ProSource representative should never delay treatment.

**WORKERS' COMPENSATION EMPLOYERS FIRST REPORT OF INJURY**  
**COMPLETE WITHIN 24 HOURS OF INJURY AND RETURN VIA FAX TO: (713) 660-9629**

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<b>CLIENT – EMPLOYER GENERAL INFORMATION</b>			
Client Company/Employer Name:			
Street Address			
City, State, Zip:	Tel:	Fax:	
Email Address:			

<b>EMPLOYEE INFORMATION:</b>			
Employee Name (Last, First, MI):*		Date of Hire:	
Street Address:		Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
City, State, Zip:		Social Security Number:	
Employee's Spoken Language:		Date of Birth:	
Home Phone with Area Code:		State of Hire:	TEXAS unless otherwise noted
Cell Phone with Area Code:		Marital Status*:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown
Occupation/Job Title:*		# of Dependents:	
Email address:			

<b>WAGE INFORMATION:</b>	
Full Pay for Day of Injury:	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>OCCURRENCE INFORMATION:</b>			
Type of Claim:	<input type="checkbox"/> Record Only <input type="checkbox"/> Medical Only <input type="checkbox"/> Lost Time	Last Work Date:	
Date of Injury/Illness:		Date Employee Notified of Injury:	
Time Employee Began Work:	__ : __ AM __ PM	Time of Occurrence:	__ : __ AM __ PM
Date Disability Began:			
Supervisor Name:		Supervisor Phone Number:	
Witness Name (1)		Tele #	
Witness Name (2)		Tele #	
Witness Name (3)		Tele #	
Describe Nature of Injury or Illness:			
Part of Body Affected:			
Cause of Injury:			
Complete Name of Business/Residence Address, Street, City, State, Zip where accident or illness exposure occurred:			

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Describe equipment, material or chemicals employee was using when accident or illness exposure occurred:	
Specify activity the employee was engaged in when the accident or illness exposure occurred:	
How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill	

Date Returned to Work:		If Fatal, give date of death:	
Were safeguards or safety equipment provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type of equipment:	
Were they used?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**PHYSICIAN/TREATMENT INFORMATION:**

Physician/Health Care Provider Full Name:		Telephone Number including area code:	
Physician/Health Care Provider Street Address, including City, State, and Zip		Fax Number including area code:	

Hospital Name:		Telephone Number for Hospital Including Area Code:	
Hospital Street Address, including City, State, and Zip			

INITIAL TREATMENT:	<input type="checkbox"/> NO MEDICAL TREATMENT	<input type="checkbox"/> MINOR BY EMPLOYER	<input type="checkbox"/> MINOR CLINIC/HOSPITAL	<input type="checkbox"/> EMERGENCY CARE	<input type="checkbox"/> HOSPITALIZED >24 HOURS	<input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED
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**OTHER INFORMATION:**

Date Administrator or Supervisor was notified of Accident or Injury:	
Preparer's Name & Title:	
Preparer's Phone Number:	
Today's Date:	
E-mail address:	

**PLEASE SUBMIT A SEPARATE SHEET FOR ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO PROVIDE REGARDING THIS ACCIDENT/INJURY.**