EMPLOYEE ACCIDENT REPORT - WORKER'S COMPENSATION

All accidents involving Apollo Professional Solutions, Inc. Employees must be reported immediately to Human Resource Manager at (866) APS-EDGE or via email, HR@apollopros.com. Completed form is faxed to Human Resource Manager (603) 890-6668 **within 24 hours of Accident**.

Section II. EMPLOYEE INFORMATION (*To be completed by Employee if able*)

Name: ______________________ Social Security Number: __XXX – XXX - ________

Job Title: ______________________ Time in Job (Yrs. /months.): ______________

Home Address: ______________________ City, State, and Zip Code: ______________

Home Telephone Number: ______________ Emergency Contact Name/Number: ______________

Section I. GENERAL INFORMATION (*To be completed by Employee if able*)

Company working for: ______________________ Company Address: ______________

Started work that day: ______________ Date/Time of the accident: ______________

Location of the accident: ____

Nature of Injury / Illness: ______________ Re-injury - provide original injury date: ______________
(Be specific as to cut, break, strain, sprain, bruise, etc.)

Section III. ACCIDENT INFORMATION (*To be completed by Employee if able*)

Location of accident: ____

When was the accident reported: ______________ To whom was the accident reported: ______________

Employee's activity when accident occurred: ______________________________

Names of witnesses to accident: ______________ Contact Number for Witnesses: ______________

INCIDENT SUMMARY: Brief description of how the accident occurred (state exactly what you were doing and any equipment that was involved): ______________________________

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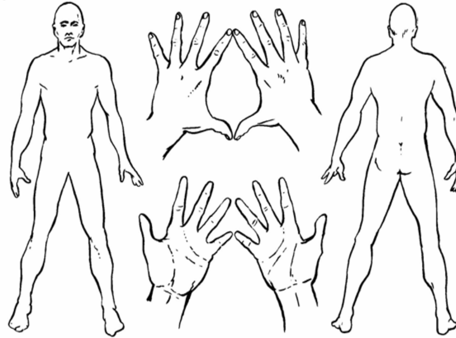
Apollo PROFESSIONAL SOLUTIONS INC

Please Indicate Location(s) of Injury(s):



Section IV. ACCIDENT INVESTIGATION SUMMARY REPORT (*To be completed by Human Resource Manager*)

CHECK all that apply below:

Injury
____ First Aid
____ OSHA Recordable (No Lost Time No Restricted Duty)
____ OSHA Lost Time
____ OSHA Restricted

Other Incidents
____ DOT Reportable
____ Vehicle Accident
____ Property Damage
____ Fire
____ Spill
____ Other (theft, non APOLLO injury, adverse PR, etc.)

Damage (V = Vehicle, P = Property)

____ Non Apollo Vehicle or Property Damage > $1,000
____ Non Apollo Vehicle or Property Damage < $1,000
____ Apollo Vehicle or Property Damage > $1,000
____ Apollo Vehicle or Property Damage < $1,000

NUMBER OF LOST DAYS __________ **NUMBER OF RESTRICTED DAYS** __________
(Days lost or restricted must be updated weekly along with OSHA Log)

PLEASE CHECK INJURY CAUSE:

____ Material Handling/Exertion
____ Tool Use
____ Slip, Trip and Fall
____ Sharp Object
____ Thermal Burns
____ Fall from Above
____ Stuck by/Caught Between
____ Chemical Related
____ Particle in Eye
____ Struck Against
____ Power Equipment Use
____ Other: ______________________________

ACCIDENT SEQUENCE: (Describe in order, sequence of events. Attach additional page if more space is needed)

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INCIDENT INVESTIGATION REPORT DATE: ______________________________________

Witness comments: ____

____

Supervisor comments: ____

____

____

Section V. MEDICAL TREATMENT (*To be completed by Employee if able*)

First-Aid administered at Facility: ________ Yes ________ No

If YES, describe treatment: ____

____

Medical Attention received outside of Facility: ________ Yes ________ No
If YES, complete the following:

Clinic/Hospital Name: ____

Clinic/Hospital Address: ____

Treating Physician: ______________________________ Phone: ____________________

Initial Diagnosis: ____

Date of Diagnosis (If different from occurrence date): ____________________________

Employee released to work: ________ Yes ________ No

Employee released to work for: ____________ Full Duty ____________ Modified Duty

If Modified Duty, describe restrictions: _______________________________________

____

____

Section VI. CHECKLIST (*To be completed by Employee if able*)

THE FOLLOWING ITEMS MUST BE CHECKED OFF AND COMPLETED WITH A COPY SENT TO THE HUMAN RESOURCE MANAGER BEFORE THIS FORM IS CONSIDERED COMPLETE:

CHECK:

_____ 1. Copies of all Information from the treating physician

_____ 2. Obtain signatures of Employee, Supervisor and Branch Manager

_____ 3. Call Human Resource Manager (866-APS-EDGE EXT 4895) to inform of Accident
Date and Time Called: ____________________

Any questions or concerns regarding the reporting or investigation of an accident may be directed to HUMAN RESOURCES – 866-APS-EDGE.

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EMPLOYEE SIGNATURE *(if able)* Date

____

SAFETY COMMITTEE SIGNATURE Date

____

BRANCH MANAGER SIGNATURE Date

WORKERS COMPENSATION ACCIDENT REPORTING

REQUIRED FORMS

- Apollo Professional Solutions, Inc. Employee Accident Form

WHAT TO DO WHEN AN ACCIDENT OCCURS

- In cases of an accident involving on-site medical, off site medical, modified duty, or loss time, the Employee Accident Report should follow an immediate verbal, or voice message notification to Human Resource Manager. Initial communication should provide injured Employee name, treating physician name and telephone number, facility name, and type of injury.
- Accident report is completed immediately following the incident except in cases of emergency. In all cases, report should be completed and sent to Human Resource Manager within 24 hours.
- Fax the following documents to Human Resource Manager attention (603) 890-6668, within 24 hours (if able):
  1. Completed Accident Report
- File completed report with insurance carrier:
  1. Human Resource Manager
- Carrier will then file copy with State.
- Carrier sends a typed/completed form to: Corporate Office
- Fax Human Resource Manager a copy of physician's report, diagnosis and work status as soon as available from Employee or medical facility.
- Fax Human Resource Manager all copies of physician's follow-up work status reports and final return to work notice.
- Notify Human Resource Manager immediately if Employee does not keep any follow-up appointments.

What the Human Resource Manager does with the information.

- If Employee is on modified duty or loss time status, contact Claims Examiner.
  If an emergency, facility may contact Apollo Professional Solutions, Inc. directly at (866) APS-EDGE, Fax (603) 890-6668, attention: Human Resource Manager.
- Monitor open claims
  1. Coordinate with facilities on care and recovery of Employee.
  2. Coordinate with Client on medical updates on care and recovery of Employee.
  3. Coordinate with Insurance Carrier on care and recovery of Employee.
  4. Coordinate with attorneys during litigation to bring case to final resolution. if applicable.
- Process and analyze monthly reports on workers' compensation costs and expenses.