

MCSC - Disability Management Office
400 S Pine St., P.O. Box 30002, Lansing, MI 48909
Office: 877.766.6447 - Fax: 517.241.9926
E-mail: MCSC-DMO@michigan.gov

STATE OF MICHIGAN ACCIDENT/ILLNESS REPORT

Is this a Duty-Related Claim? Yes No

Instructions:

Please save this form to your computer as you would other Word documents. Then, please e-mail the completed form to: Disability Management at MCSC-DMO@michigan.gov

*Citizens Management, Inc. (CMI) is the State's Third Party Administrator (TPA)

**IF DEATH OR CATASTROPHE, NOTIFY
MIOSHA's HOTLINE WITHIN 8 HOURS
@ 800-858-0397**

CLAIMANT INFORMATION

Employee Name: Last:		First:	Middle:	
Employee I.D. Number:		Date of Birth (MM/DD/YYYY):		Gender:
Home Address:		City:	State:	Zip:
Work Telephone Number: Ext.		Personal Telephone Number:		
Occupation Title (Classification/Level):		Bargaining Unit/Union:	Date Hired (MM/DD/YYYY):	
Department/Agency:		TKU:	Work Location/Work Site:	
Work Address:		City:	State:	Zip:
Supervisor's Name:		Telephone: Ext:		

INITIAL INFORMATION

Date of Injury/Illness:	Time of Injury/Illness: <input type="checkbox"/> AM <input type="checkbox"/> PM	Time Work Day/Shift Started: <input type="checkbox"/> AM <input type="checkbox"/> PM	Time Work Day/Shift Ended: <input type="checkbox"/> AM <input type="checkbox"/> PM	Shift Premium Paid? <input type="checkbox"/> Yes <input type="checkbox"/> No	First Day of Absence:
Employee Reported Claim To (Name):			Date Claim Reported:		
Injured on Employer Premises: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, where?		Accident City/Township:	County:	
What were you doing just before the incident occurred?					
What Happened?					

MEDICAL INFORMATION (Reminder--Employees should utilize approved clinics.)

Extent of Injuries: <input type="checkbox"/> Treatment Refused <input type="checkbox"/> No First Aid Needed <input type="checkbox"/> Medical Treatment (Returned to Work by Next Scheduled Work Shift)		<input type="checkbox"/> Disabling Injury (Regular) <input type="checkbox"/> Disabling Injury (Assault)* <input type="checkbox"/> Fatality	*Public Act # _____ (Assault) <input type="checkbox"/> Yes <input type="checkbox"/> No
Name, address, telephone number of medical provider(s):			
Were you hospitalized for this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, where?	How many days hospitalized?
Was a prescription given? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did you take time from work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long? From: _____ To: _____	
Anticipated return date?		Date of next doctor's appointment?	
Comments:			

ADDITIONAL INFORMATION

<p>Place Where Accident Occurred:</p> <input type="checkbox"/> Auditorium <input type="checkbox"/> Cell Block (Identify # _____) <input type="checkbox"/> Dining Room <input type="checkbox"/> Farm <input type="checkbox"/> Gymnasium <input type="checkbox"/> Health Care <input type="checkbox"/> Hospital/Infirmary <input type="checkbox"/> Industries <input type="checkbox"/> Kitchen <input type="checkbox"/> Laundry <input type="checkbox"/> Linen Room <input type="checkbox"/> Living Unit <input type="checkbox"/> Lobby <input type="checkbox"/> Maintenance <input type="checkbox"/> Office <input type="checkbox"/> Outside Facility Area <input type="checkbox"/> Outside Grounds/Yard <input type="checkbox"/> Parking Lot <input type="checkbox"/> Post <input type="checkbox"/> Rotunda <input type="checkbox"/> School <input type="checkbox"/> Warehouse <input type="checkbox"/> Other _____	<p>Nature of Injury:</p> <input type="checkbox"/> Amputation <input type="checkbox"/> Abrasion <input type="checkbox"/> Bite or Sting <input type="checkbox"/> Burn (not electric) <input type="checkbox"/> Concussion <input type="checkbox"/> Contusion (bruise) <input type="checkbox"/> Crush <input type="checkbox"/> Dislocation <input type="checkbox"/> Dermatitis <input type="checkbox"/> Drowned <input type="checkbox"/> Fracture <input type="checkbox"/> Frost Bite <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Heart Failure <input type="checkbox"/> Hernia (rupture) <input type="checkbox"/> Inflammation/Irritation <input type="checkbox"/> Internal Infection <input type="checkbox"/> Laceration <input type="checkbox"/> Mental/Emotional <input type="checkbox"/> Multiple Injuries <input type="checkbox"/> Poison <input type="checkbox"/> Puncture <input type="checkbox"/> Shock (electrical) <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Suffocation <input type="checkbox"/> Wound <input type="checkbox"/> Other _____	<p>Body Part(s) Injured:</p> <input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle(s) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Arm(s) Lower <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Arm(s) Upper <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Back <input type="checkbox"/> lower <input type="checkbox"/> upper <input type="checkbox"/> Chest <input type="checkbox"/> Ear(s) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Elbow(s) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Eye(s) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Face <input type="checkbox"/> Finger(s)/Thumbs <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Foot (Feet) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hand(s) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Head <input type="checkbox"/> Hip(s) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Internal Organs <input type="checkbox"/> Knee(s) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Leg(s) Lower <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Leg(s) Upper <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Mouth <input type="checkbox"/> Multiple Body Parts <input type="checkbox"/> Neck <input type="checkbox"/> Nose <input type="checkbox"/> Rib(s) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Shoulder(s) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Skull <input type="checkbox"/> Toe(s) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist(s) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Other _____	<p>Type of Accident:</p> <input type="checkbox"/> Collision <input type="checkbox"/> Falling or Striking Against <input type="checkbox"/> Struck by Moving Object <input type="checkbox"/> Struck by Prisoner/Patient/Subject <input type="checkbox"/> Lifting or Over Exertion <input type="checkbox"/> Caught In, On, or Between <input type="checkbox"/> Contagious Illness <input type="checkbox"/> Struggle w/ Prisoner/Patient//Subject <input type="checkbox"/> Handling Object <input type="checkbox"/> Contact with Irritants <input type="checkbox"/> Exposure to Heat or Cold <input type="checkbox"/> Burn (Not Electrical) <input type="checkbox"/> Disturbance <input type="checkbox"/> Shock (Electrical) <input type="checkbox"/> Industrial Disease <input type="checkbox"/> Motorized Vehicle <input type="checkbox"/> Other _____		
<p>Was employee in parking lot when they slipped/fell? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>Was employee on sidewalk when they slipped/fell? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Party Responsible for Maintenance:</p>	<p>Address:</p>	<p>City:</p>	<p>State:</p>	<p>Zip:</p>	<p>Telephone:</p>
<p>Injury Source Item(s):</p> <input type="checkbox"/> Automobile/Van/Etc. <input type="checkbox"/> Box/Container <input type="checkbox"/> Cleaning Chemical <input type="checkbox"/> Door <input type="checkbox"/> Eating Utensil <input type="checkbox"/> Hand Tool <input type="checkbox"/> Hot Food <input type="checkbox"/> Hot Water <input type="checkbox"/> Prisoner (ID # _____) <input type="checkbox"/> Kitchen Utensil/Equipment <input type="checkbox"/> Laundry Equipment <input type="checkbox"/> Office Equipment <input type="checkbox"/> Other Employer <input type="checkbox"/> Power Tool <input type="checkbox"/> Stairs <input type="checkbox"/> Temperature Extreme <input type="checkbox"/> Wall <input type="checkbox"/> Window <input type="checkbox"/> Other _____			<p>Contributing Factors:</p> <input type="checkbox"/> Defective Tools, Equipment <input type="checkbox"/> Proper Equipment Not Provided <input type="checkbox"/> Proper Equipment Not Used <input type="checkbox"/> Failure to Follow Rules or Instruction <input type="checkbox"/> Lack of Knowledge or Instruction <input type="checkbox"/> Unsafe Act <input type="checkbox"/> Failure to Make Proper Inspection <input type="checkbox"/> Contact with Another Person <input type="checkbox"/> Other _____		
<p>Was injury the result of an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			<p>If yes, please fax a copy of the Traffic Crash Report to fax number:</p>		
<p>Did this involve a state vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>Or, was employee approved for use of personal vehicle in lieu of state vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Witness #1 Name:</p>	<p>Address:</p>	<p>City:</p>	<p>State:</p>	<p>Zip:</p>	<p>Telephone:</p>
<p>Witness #2 Name:</p>	<p>Address:</p>	<p>City:</p>	<p>State:</p>	<p>Zip:</p>	<p>Telephone:</p>

Form Completed By (Name):	Date:
<p>To the best of my knowledge this information is accurate and complete.</p>	