STATE OF MICHIGAN

Workers' Compensation Claim Form

Sedgwick is the State of Michigan's Workers' Compensation Third Party Administrator (TPA)

1. Employee Information

Last Name	First Name	M.I.	Employee ID

Home Address	City	State	Zip Code

Gender	Date of Birth	Work Telephone Number	Home/Cell Telephone Number	Date of Hire (mm/dd/yy)

Job Classification	Alternate Email Address

Department/Agency	Location Work Site

Supervisor's Name	Supervisor Phone Number	Supervisor Email Address

2. Injury/Illness Information

Date of injury or illness	Time of injury or illness	Time employee began work

Employee's regular schedule begins	Employee's regular schedule ends

What was employee doing just before the injury or illness occurred? Describe the activity, as well as the tools, equipment, or material the employee was using.

What happened?

Did this injury or illness result in an employee's death, amputation or loss of eye?

What was the injury or illness, including all affected body parts in order of severity? Please designate right or left, if applicable.

Was a needlestick or sharp object involved in this injury or illness?

What object or substance directly harmed employee?

Injury or illness reported to (Name and Title)

Date reported to the employer

Did employee take time off work?	Last Day Worked	Return to Work Date	Date of next doctor appointment

Name of witness(es)

Was this injury the result of an automobile accident?	If yes, was it a state owned vehicle?

Did this injury or illness occur on employer premises?		
Location of injury or illness (Building address and location within building)		
County where injury or illness occurred	City where injury or illness occurred	
Did employee receive medical treatment?	Was this injury or illness the result of slip and fall accident?	
Did injury or illness require treatment in an emergency room?		
Medical provider's name	Medical provider's address	Medical provider's phone
Was employee hospitalized overnight as an inpatient?	Healthcare facility name	Healthcare facility address
How many days in the hospital?	Medical provider's diagnosis	
Was a prescription given?	Did employee return to their regular job?	Are there any work restrictions related to the injury or illness?

3. Completed by:

Name	Email Address	Date Submitted

A person receiving benefits under the State of Michigan Disability Benefit Program must reimburse the State any benefits paid under the Program for which the recipient is ineligible because of benefits received from any source that require offset from disability benefits under the Program's terms.

The State will deposit the first Workers' Compensation payment of an employee receiving benefits under the Program to re-credit the proper amount of any leave credits used to keep the employee in full pay status and process any other necessary adjustments consistent with Civil Service rules and law. The employee will receive a check for any remaining balance. Sedgwick will send any subsequent Workers' Compensation payments directly to the employee.

State of Michigan Workers' Compensation Claim Form Instructions

Department	Employee
Attorney General Auditor General Judicial Legislative Service Bureau LEO- MEDC LEO - MSHDA Michigan State Capitol Commission Michigan Strategic Fund State State Police	1. Immediately notify your supervisor of the work related injury/illness. 2. Complete all sections of the claim form. 3. Provide a copy of the completed claim form to your supervisor and HR office. 4. Retain a copy for your records. **For questions, contact your HR office.**
Corrections	1. Immediately notify your supervisor of the work related injury/ illness. 2. Complete all sections of the claim form. 3. Provide a copy of the claim form to your supervisor and HR office. 4. Retain a copy for your records. **For questions, please contact the DMU at 877-443-6362, select option 1.**
All Other Agencies	1. Immediately notify your supervisor of the work related injury/illness. 2. Complete all sections of the claim form. 3. Return the completed form to the Civil Service Commission Disability Management Office (DMO) by email at MCSC-DMO@michigan.gov or by fax at 517-241-9926. 4. Provide a copy of the claim form to your supervisor and retain a copy for your records. **For questions, contact the DMO at 877-443-6362, select option 2.**