AMS

CLIENT ACCIDENT PROCEDURES

WORKERS' COMP. DEPARTMENT
14160 Dallas Parkway, Suite 500
Dallas, Texas 75254
PHONE (972) 404-1615
(800) 728-0623
FAX (972) 404-4450

1. If the injury is not serious, call the Workers' Comp. Department at AMS first. They can assist in directing to the proper medical facility. An AMS representative will attempt to call the provider prior to treatment being rendered. This will avoid delay in treatment and assure proper billing.

   DO NOT GO TO VOICE-MAIL WHEN REPORTING NEW INJURIES
   DIAL 0 AND HAVE THE OPERATOR ANNOUNCE OVER THE INTERCOM THAT A "NEW INJURY" IS HOLDING

2. If it is an emergency situation that requires an ambulance or immediate transport, take care of the employee first, then immediately report the claim to the WC Department. You need to let the medical provider know that a drug test is required.

3. If it is a weekend or after business hours, take the injured worker to the nearest medical facility. Ensure that the provider will conduct a 10-panel drug test. Report the claim to AMS on the next business day.

4. Be certain that in all cases the medical provider understands that the patient is an AMS employee, and that we require a drug screen for all accidents. Also the medical provider needs to be aware that we are able to accommodate any light duty restrictions.

5. **THE EMPLOYEES INJURY / INCIDENT REPORT NEEDS TO BE COMPLETED AND SIGNED BY THE EMPLOYEE.** We need a Supervisor and Witness Report on each incident. If no witness, please indicate so on the Witness Report. Forms are required on all injuries to be faxed to AMS within 24 hours after an injury.

6. If an employee is released to duty with restrictions, these restrictions must be followed. If an employee is released to work and then at a later time is taken off work status from a medical provider you need to immediately contact AMS Workers' Compensation Department to notify us of this disability.

WE MUST GET A FAX OF THE EMPLOYEES WORK STATUS IMMEDIATELY AFTER HIS FIRST VISIT TO ASSURE THAT THEIR DISABILITY PAY STARTS ON TIME. THE LACK OF A STATUS REPORT FROM THE DOCTOR IS THE MOST COMMON REASON FOR DELAY.

WE DO NOT APPROVE TREATMENT UNLESS WE HAVE HEARD FROM SOMEONE IN A SUPERVISORY CAPACITY AT YOUR LOCATION THAT THERE HAS BEEN A JOB RELATED INJURY.

Please help us help you. These procedures have repeatedly proven to help us protect you and us from frivolous litigation.

AMS STAFF LEASING

SUPERVISOR'S REPORT OF ACCIDENT

COMPLETE ALL BLANKS

Date of this report_______________ Date & Time of injury_________________
Name of injured worker____________________________ SS#___________________
Date of hire______________ Date employee reported incident______________
Employee occupation_____________ Hire date_________Time of incident __________
Person employee reported incident to:___________________________________
Client where incident occurred____
Address where incident occurred_______________________________________
Has employee lost time from work? (If yes, give dates of lost time and if employee has returned to work) _
____

Describe the incident in detail (how, why, where, what)_____________________
____
____

Is a third party (another company or individual) responsible for this incident? If yes, please detail____
____

Type of injury (cut, sprain, bruise, fracture, etc.)___________________________
Which part of body injured (be specific)_________________________________
Are there any safety issues that contributed to this injury? If so, please detail:__________
____
____

List all witnesses to this incident:______________________________________
____

Name of Medical facility where employee taken____________________________
Phone # and address of medical provider_________________________________
____

Do you know, or have you heard, any information regarding this incident that AMS should know? ____
____

Supervisor or Foreman completing this report:_____________________________
Print name and phone #

Signature_________________________________

REPORT DUE WITHIN <u>24 HOURS</u> OF ACCIDENT!!!!!!!!!

*Please ensure that employee incident report and witness statement report are completed

Fax all completed forms to 972-404-4450

AMS STAFF LEASING

WITNESS STATEMENT

COMPLETE ALL BLANKS

Name of Witness______________________________ Date of this report________________
Employed by___________________________

Name of injured worker____________________________________
Date & Time of injury____________
Client where incident occurred____
Address where incident occurred____

Are you related to the injured worker?___________
How long have you known the injured worker?_______________________

DID you actually see the incident?__________________________
Explain, in detail, what you saw or know regarding this incident:_________________
____
____
____
____
____

List names of any other persons who may have information regarding this incident:_____
____
____

Is there any other information that you know that would assist in providing a fair evaluation of this incident?____
____
____

Print name_______________________ Signature______________________________
Phone #:________________________

Fax completed report to 972-404-4450

AMS STAFF LEASING
EMPLOYEE INCIDENT REPORT
COMPLETE ALL BLANKS

Date & Time of injury____

Name of injured worker_______________________ SS#___________________
Address____________________________________ Home Phone_____________
Date of Birth_____________ Martial Status____________ #Dependents_______
Date of hire____________________ Weekly wages________________________
Injury reported to:_____________________ Date injury reported_________________
Client where incident occurred____
Address where incident occurred____
Where you taken off work status from your doctor______________________________
Describe the incident in detail (how, why, where, what)_______________________
____
____

Type of injury (cut, sprain, bruise, fracture, etc.)_____________________________
Which part of body injured (be specific)____
Are there any safety issues that contributed to this injury? If so, please detail:__________
____
____

List all witnesses to this incident:____
____

List all prior injuries sustained at work and outside of work in the last 10 years that required medical attention (list body parts and dates):_____________________________
____

I, employee, the undersigned, certify that the above is a true and correct statement of fact and that I made such statements of my own free will. I understand that any payments to me or anyone else for expenses in connection with my accident and resulting injury is not an admission of liability on the part of **AMS.** I authorize full access to copies of medical records, radiology reports, drug/alcohol screenings, and documents of any kind relating to my past or present injury/illness to **AMS**. I herby agree to release this information and hold all such medical providers harmless for the release of this information as set forth in this authorization.

______________________	__________________	_________________________
EMPLOYEE SIGNATURE	**DATE OF REPORT**	**TRANSLATED by (if necessary)**

AMS will prosecute to the fullest jurisdictional extent for all fraudulent claims reported.
PER AMS employment policy, a drug test is mandatory on all reported claims.

Fax completed report to 972-404-4450