



Internal Use Only Date Received: _____

IMPORTANT! If a workplace injury or illness is reported to you, immediately refer the injured employee to the pre-designated medical clinic. All incidents, regardless of severity, must be reported to DynamicHR within 24 hours. Please complete this form and return to DynamicHR by faxing to 248-370-0968.

THERE ARE STRICT TIME PERIODS IN WHICH ALL CLAIMS MUST BE REPORTED. LATE REPORTING MAY RESULT IN FINANCIAL PENALTIES IMPOSED BY THE STATE.

Please Print Clearly

Employee Information:

Employee: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: Married () Single/Divorced () Number of Dependents: _____

Does the injured employee speak English? Yes () No ()

Date of Birth: ____/____/____ Date of Hire: ____/____/____

Employee Occupation: _____

Worksite Employer Information:

Temporary Service Agency: PCMI

District: _____ District Supervisor Name: _____

District Supervisor Phone: _____

Policy Location # 49 Address: 212 KENT STREET, SUITE 12 City: PORTLAND State: MI Zip: 48875

Benefit State (Where the injury happened): _____

Accident Information:

Date of incident/accident/injury/illness: ____/____/____ Date reported to Dynamic: ____/____/____

Time Employee Began Work on Date of Incident: _____AM PM Time of Incident: _____AM PM

Address where the actual accident/injury/illness occurred: _____
(PLEASE ENTER FULL ADDRESS)

County where the accident/injury/illness occurred: _____

Describe the injury or illness (i.e. cut on hand, fractured finger, object in eye): _____

Part of body directly injured (i.e. back, left wrist, right eye): _____

Has the employee died? () Yes () No If yes, date of death: _____

Did the employee receive medical treatment? No () Yes ()

If yes, where? _____ Contact Name: _____
(MEDICAL PROVIDER)

Address: _____ Phone: _____

Did the employee miss any work? Yes () No () Last day employee worked: _____

Has the employee returned to work? Yes () No () Date employee returned to work: _____

Was the employee performing their normal job duties when the incident occurred? No () Yes ()

What was the employee doing before the incident? _____

Incident Description:

How did the incident occur? (Please describe fully the events that resulted in the incident / exposure. Describe what happened, how it happened and anything about the scene that may have contributed to the incident occurring. Attached additional sheet if necessary)

Name of witnesses to incident / exposure (First and Last name and telephone numbers):

Name: _____ Phone: _____ Email: _____

Name: _____ Phone: _____ Email: _____

Do you question the validity of the claim of injury/illness? No () Yes () If yes, why?: _____

Additional Comments:

Completed by: _____ Phone: _____ Date: _____

Supervisor/Manager Signature (if completed by employee): _____