Explanation of Employee Obligations When Reporting a Work-Related Injury

***** Please read this entire document carefully *****

- During business hours, you must be seen at one of the following facilities. Whenever possible, call ahead to alert them that you are on your way.

  AFC Urgent Care https://www.afcurgentcare.com/
  45 Drum Hill Road, Chelmsford, MA 01824
  Tel: 978-528-3033 Normal Business Hours: 8:00 AM to 5:00 PM, Everyday

  ExpressMed https://expressmedboac.com/
  159 North Broadway, Salem, NH 03079 Normal Business Hours: 8:00 AM to 7:00 PM, Monday - Friday
  Tel: 603-898-0961 9:00 AM to 4:00 PM, Saturday

- Outside of the normal business hours for the two Occupational Health clinics above, you can be seen at the Lowell General Emergency Room (either campus) or the Holy Family Emergency Room.
- If you are seen at the Emergency Room outside of normal hours of operation for these two facilities, you MUST make a follow-up appointment at AFC or ExpressMed the following day.
- You may also follow up with your own physician after being seen by one of these facilities.
- If the injury results in lost time from work exceeding five (5) days, a representative from Trinity's workers compensation insurance company will contact you.
- During the State of Massachusetts five (5) day waiting period of a lost-time claim, you can choose to be paid with any available vacation or sick time. Beyond five (5) days, an approved claim for lost wages will be paid by the workers compensation carrier at the State of Massachusetts-allowed rate based on your wages over the prior 12-month period.
- This package must be completed in its entirety and submitted to a Supervisor or Manager no later than 24 hours after the time of injury. Failure to follow these guidelines may result in the denial of your claim.
- You must supply the Human Resources department and the Workers Compensation Insurance representative with all doctor's notes pertaining to your injury.
- If your injury results in modified work duty, you must be available to work any and all modified duty assignments.
- Prior to returning to work, you will be required to provide the Human Resources department with a doctor's note releasing you for full-duty without restrictions.
- In the event that you remain out of work as a result of this injury, it is important that you remain in contact with Human Resources on a weekly basis.

By signing below, you, as an employee of Trinity EMS, Inc. acknowledge that you have read and will abide by the guidelines outlined herein. You also acknowledge that failure to comply with any or all of these guidelines may result in termination of workers compensation benefits or a denial of your claim.

** Important Note: If this incident is related to a work-related exposure, please see a Manager or Supervisor for different instructions.

Employee Name (Printed): _____ Date: _____

Employee Signature: _____

Workers Compensation Accident Report

This form is to be completed by a Supervisor/Manager and the injured employee immediately. Please print.

Check One: _____ First Aid Only _____ Occupational Health / Emergency Room

Name of Facility: _____

Date of this Report: _____

Date of Accident: _____ Time of Accident: _____ AM / PM

Employee Name: _____

Supervisor Name: _____

Employee's Scheduled Hours Per Week: _____

Employee's Normal Work Schedule: (Describe in detail)

_____

_____

Describe the injury and body part injured. Please provide as much detail as possible.

_____

_____

_____

Where did the injury take place? Be specific.

_____

_____

How did the injury occur? Explain in detail.

_____

_____

_____

TRINITY
EMERGENCY MEDICAL SERVICE

List any witnesses to the incident (names/titles):

_____

_____

What tools, equipment or materials were being used at the time of the incident?

_____

_____

Were Trinity EMS safety procedures being followed at the time of the incident? If not, why not?

_____

_____

Causes. What causes, failures to act, or conditions contributed directly to this incident?

_____

_____

Action Plan. What will be done to prevent similar incidents in the future?

_____

_____

_____

Other Comments / Information:

_____

_____

Employee Signature: _____ Date: _____

Supervisor / Manager Signature: _____ Date: _____