Michigan Educational Transportation Services

1240 Grand River Ave, Ste. B2 • Portland, MI 48875 • 517-647-7765 • Fax: 517-647-7572

METS WORKERS COMPENSATION PROCEDURE

When a METS employee is injured while on assignment, it's important that the following process be carefully followed to ensure the employee receives immediate care when medically necessary and any/all follow up treatment is managed in a timely manner.

PLEASE DO NOT KEEP BLANK FORMS ON FILE FOR FUTURE USE!

- In the event of injury, please always first refer to www.contractbusdrivers.com. Click on **District Resources**. Click on **Accident/Injury**. Please don't keep copies of our Injury Report on file, but always refer to our website in order to order to ensure that you have the most up to date version of our forms.

- All injuries for METS employees must be reported to us by utilizing the **METS Injury Report** within 24 hours (or the next school day) following the injury. This includes minor injuries that do not require medical treatment (example: small cuts, bruises, sprains, etc.)

- If an incident is minor or does not require medical treatment, the **METS Injury Report** should be completed at the time of incident and faxed directly to our Workers Compensation Representative at 517-647-7765.

- If an injury requires immediate medical attention, Please call 517-647-7765 or our emergency line at 517-743-1639 to report and obtain an **Authorization for Treatment Form**. This form will be faxed or e-mailed immediately so that it may accompany the employee to the treatment facility. In cases of a true emergency or life threatening injury, when notified, METS will call the treatment facility to give verbal authorization. Our employee must be sent to the nearest METS approved facility or emergency room in case of true emergency. The **Injury Report** should be completed as soon as possible, typically no later than 24 hours following injury.

- We expect our employees to communicate directly with you regarding restrictions, time off work, release to full duty, etc. It's important that our employees communicate with METS as well. Please, when necessary, remind them of this. Fax any documentation you receive to 517-647-7572 or scan and e-mail to hrdept@contractbusdrivers.com.

- METS employees are required to attend all scheduled appointments related to the treatment of their injuries. On days that the employee is scheduled to work, they are expected to schedule their appointment around their work schedule.

Questions? Call the METS Workers' Compensation Representative at 517-647-7765

METS Employee Injury Report

Please Fax to 517-647-7572 or scan and e-mail to hrdept@contractbusdrivers.com

Please print clearly and complete all sections of the Injury Report.

Employee Name: _____
Last First Middle

Date of Birth: _____ Date of Hire: _____

_____
Home Street Address Apt#/PO Box City State Zip

_____
Cell Phone (include area code) Secondary Phone (include area code)

E-Mail Address: _____

Position Working: _____ School or Location: _____

On Site Supervisor Name, if applicable: _____

Date of Incident: _____ Time of Incident: _____ ☐ a.m ☐ p.m. Date Reported: _____

Worker's Shift: (from) _____ ☐ a.m. ☐ p.m. to _____ ☐ a.m. ☐ p.m.

Location Where Incident Occurred: _____

_____
Address Where Incident Occurred City State Zip

What was employee doing when accident occurred? (Be specific) _____

_____

Was there an unsafe condition that contributed to the injury? ☐ yes ☐ no If yes, please specify conditions:

Nature of Injury (strain, cut, bruise, ect.):

Body Part(s) Affected: _____

What object/substance directly harmed the employee? _____

_____

What could have been done to prevent this injury? _____

_____

Were proper procedures being followed when incident occurred? ☐ yes ☐ no If no, explain:

Medical Treatment Required? ☐ None ☐ First Aid Only ☐ Doctor or Hospital

Name of Doctor or Hospital where treatment was sought: _____

Address of Doctor or Hospital where treatment was sought: _____

Contact number of Doctor or Hospital where treatment was sought: _____

List All Witnesses: _____
Print Full Name Contact Phone Number (include area code)

_____
Print Full Name Contact Phone Number (include area code)

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

I hereby declare that the facts stated above are true

_____
Employee Signature Date

If an employee receives medical treatment from a doctor or hospital, additional forms/information may need to be filled out/provided for a Workers Compensation claim to be filed.