Since 1983 **mancon**

1961 Diamond Springs Road
Virginia Beach, VA 23455
Phone: (757) 457-9312 or (888)892-0787

REPORT OF INCIDENT

Date:_____ Involved MANCON Employee's Name and ID#:_____
Assigned Work Location:_____

Type of Work:
- ☐ Administrative
- ☐ Professional
- ☐ Management
- ☐ Technical
- ☐ Maintenance
- ☐ Other _____

Type of Accident (Check all that apply):
- ☐ Automobile Accident (send to Fleet Mgr)
- ☐ Building or Facilities (send to Fleet Mgr)
- ☐ Employee Personal Injury (send to HR)
- ☐ Equipment Damage (send to Fleet Mgr)
- ☐ Public (Property or Personal) Injury (send to Fleet Mgr)
- ☐ Other _____(send to both HR and Fleet Mgr)

ACCIDENT DETAILS:

1. Date of Incident:_____ Time Incident Occurred:_____ Time Work Shift Started: _____ Date Reported:_____
2. Incident Physical Address:_____
   Details regarding the incident at the site:_____
3. Description of Incident (Include all details: what happened, who was doing what at the time of the incident, what safety equipment is required for the task, what safety equipment was used for the task, what possibly caused the accident, etc. Attach additional pages as needed):
4. Automobiles Damaged (complete then proceed to Page 3-4): _____
5. Injury Sustained (complete then proceed to Page 5): _____
6. Equipment Involved/Damaged (complete then proceed to Page 6):_____
7. Property Involved/Damage (complete then proceed to Page 6):_____
8. Cause of Accident (Be Specific):_____
9. Supervisor's Name/Contact information:_____
10. Describe possible causes for incident:_____
11. Describe Physical Evidence at Scene of the Incident (Dropped boxes, Broke equipment, etc.):_____

11. Initial and provide Date/Time the Incident was called into MANCON Corporate.
    Human Resources?_____ Date/Time Called In:_____
    Fleet Manager?_____ Date/Time Called In:_____

Employee's Signature:_____ Site Supervisor's Signature:_____
Human Resources Signature/Date notified: _____Date Received:_____

FORWARD COPY WITHIN 24 HOURS OF INCIDENT TO MANCON® CORPORATE OFFICE
HUMAN RESOURCES ATTN: LAURA SIPES – FAX 757-457-9345 or EMAIL LSIPES@MANCONINC.COM
FLEET MANAGER ATTN: TONY SCHNEIDER – FAX 757-457-9354 or EMAIL TSCHNEIDER@MANCONINC.COM

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Fleet Manager Signature/Date notified: _____ Date Received: _____

AUTOMOBILE ACCIDENT REPORT

Make copies for completion for each MANCON person/vehicle involved.
Send this form to Fleet Manager with other reports.

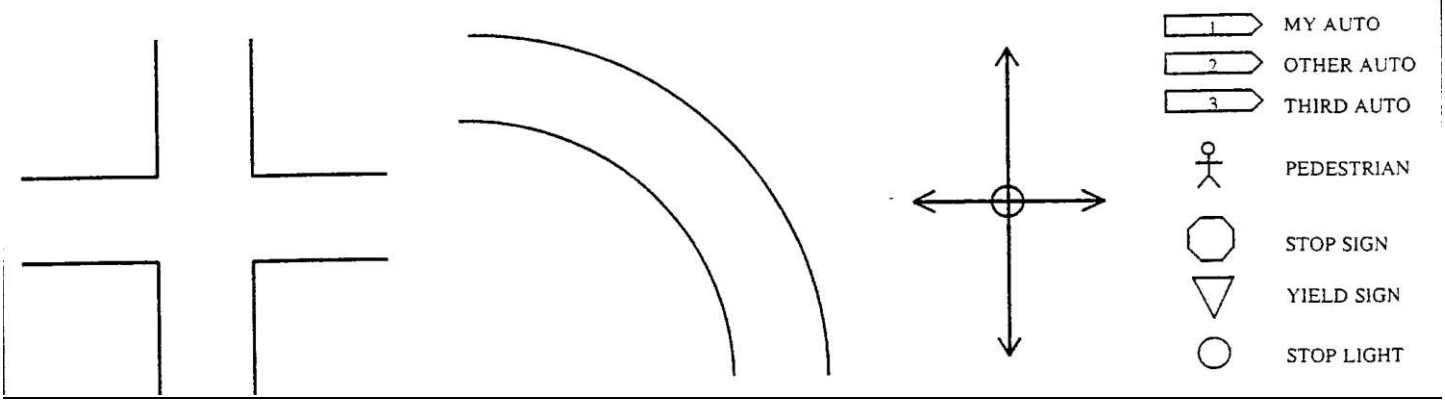
MANCON Driver: _____ DOB: _____ Male/Female: _____
MANCON Driver License information: _____ Phone: _____
MANCON Driver Address: _____

MANCON Location and Name Vehicle is assigned to: _____
Purpose for use of Vehicle: _____
Year: _____ Make: _____ Model: _____ VIN: _____
Vehicle License Plate: _____
Location of MANCON Vehicle after Accident: _____
Estimated Cost of Repairs: _____ Vehicle Garaged at: _____

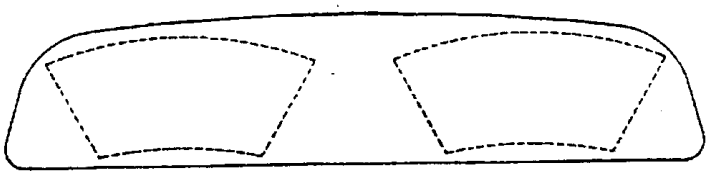
Passenger 1 in MANCON Vehicle: _____ Phone: _____
Passenger Address: _____
Passenger 2 in MANCON Vehicle: _____ Phone: _____
Passenger Address: _____
Passenger 3 in MANCON Vehicle: _____ Phone: _____
Passenger Address: _____

Using the diagrams and lines below, draw and describe the accident and damage to MANCON Vehicle.

SHOW ON THE DIAGRAM THE POSITIONS OF ALL AUTOS, PERSONS, STOP LIGHTS, STOP SIGNS AND OTHER OBJECTS. SHOW STREET NAMES



WINDSHIELD DAMAGE: CHECK ITEMS ABOVE AND MARK LOCATION ON DIAGRAM:



_____
_____
_____
_____

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AUTOMOBILE ACCIDENT REPORT

Make copies for completion for each NON-MANCON person/vehicle involved.
Send this form to Fleet Manager with other reports.

Name of the Other Driver: _____ Phone: _____
Other Driver License information: _____
Address: _____
Insurance Company: _____ Phone: _____
Insurance Address: _____
Owner of Other Vehicle: _____ License Plate: _____
Year: _____ Make: _____ Model: _____ Other Identifying Features: _____
Estimated Cost of Repairs: _____

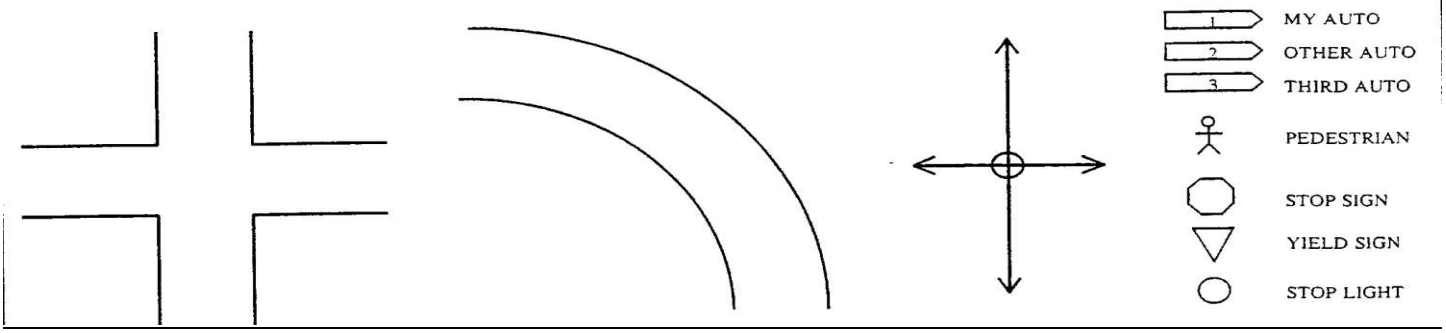
Passenger 1 in MANCON Vehicle: _____ Phone: _____
Passenger Address: _____
Passenger 2 in MANCON Vehicle: _____ Phone: _____
Passenger Address: _____
Passenger 3 in MANCON Vehicle: _____ Phone: _____
Passenger Address: _____

If the Police were contacted, provide the officer's name and report number (also attach a copy of the accident report filed).

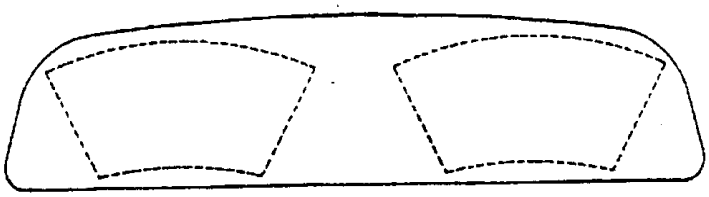
_____

Using the diagrams and lines below, draw and describe the accident and damage to other Vehicle.

SHOW ON THE DIAGRAM THE POSITIONS OF ALL AUTOS, PERSONS, STOP LIGHTS, STOP SIGNS AND OTHER OBJECTS. SHOW STREET NAMES



WINDSHIELD DAMAGE: CHECK ITEMS ABOVE AND MARK LOCATION ON DIAGRAM:



_____
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INJURY INFORMATION

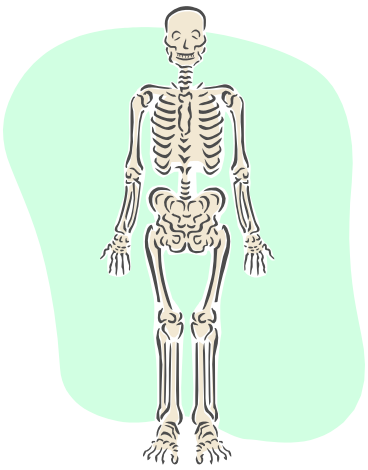
Make copies for completion for each person injured.
Send this form to Human Resources with other reports.

Injured Name: _____ Phone _____
Address _____ Job Title _____
_____ Department _____
Date of Birth: _____ Female/Male _____

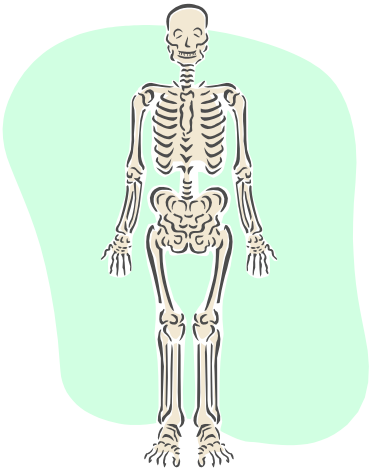
First Aid Provided on Site? _____ If Transported Off-Site, How? _____
Employee (Choose one): ☐ Remained at work ☐ Returned to Work at _____ ☐ Did not return to work

Employer/Contact Name/Phone (if not MANCON) _____
Employer Address and Phone: _____

FRONT SIDE



BACK SIDE



Indicate the area(s) injured using the graphics above for the front and back side. Description lines are provided for your convenience.

_____
_____
_____
_____
_____
_____
_____

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EQUIPMENT AND/OR PROPERTY DAMAGE

Make copies for completion for each piece of equipment and/or property damaged.
Send this page to Fleet Manager with the other reports.

Owner of Equipment or Property: _____
Address of Owner: _____
Contact Name/Phone: _____

Insurance Company: _____ Phone: _____
Insurance Address: _____

Estimated Cost of Repairs: _____

If the Police were contacted, provide the officer's name and report number (also attach a copy of the accident report filed).

_____

Using the boxes above, drawn the incident/damage occurred. Description lines are provided below for a detailed description of the incident and the damage that occurred. Attach photos or other documentation of the damaged equipment/property.

EQUIPMENT DAMAGE

PROPERTY DAMAGE

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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INCIDENT WITNESS STATEMENT

Date/Time of Incident_____ _____

Date/Time of Report_____

Witness Name_____ Phone_____

Address_____ Employed By_____

_____ Address_____

Job Title_____ Department_____

Description of Incident_____

_____

_____

_____

Brief Description of Witness Activity During Incident_____

_____

_____

_____

Witness Statement Describing Incident in Detail (Including Names of All Person Involved):

_____

_____

_____

_____

_____

I have read the above and it is true to the best of my knowledge:

Signature_____ Printed Name_____

Date_____ Time_____

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RETURN TO WORK / ABILITY TO WORK RECOMMENDATION

If injuries claimed by MANCON employees, please send this three page form with the employee to the medical facility providing treatment.

Patient's Name:_____ Social Security Number:_____

TO BE COMPLETED BY TREATING/ATTENDING PHYSICIAN

Brief Diagnosis / Condition:_____

_____

_____

_____

_____

I saw and/or treated this patient on _____ and based on the above description of the Patient's current medical problem:

☐ Recommend his/her Return to Work with No Limitations on (date) _____

☐ Patient may Return on (date)_____ with a Daily Time Limitation of _____ hours

and/or Limitations specified hereinafter:

PHYSICAL LIMITATIONS

1. In an 8 hour work day, Patient may:

	Not At All	Occasionally	Frequently
A. Stand/Walk	☐	☐	☐
B. Sit	☐	☐	☐
C. Drive	☐	☐	☐
D. Use Hands Repetitively	☐	☐	☐
E. Use Feet Repetitively	☐	☐	☐
F. Bend/Stoop	☐	☐	☐
G. Twist	☐	☐	☐
H. Squat/Kneel	☐	☐	☐
I. Climb Steps/Ladders	☐	☐	☐
J. Reach/Stretch	☐	☐	☐

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ENVIRONMENTAL LIMITATIONS

2. In an 8 hour work day, Patient may:

	Not At All	Occasionally	Frequently
A. Temp. Above 100º F	☐	☐	☐
B. Temp. Below 20º F	☐	☐	☐
C. High Humidity	☐	☐	☐
D. Unventilated	☐	☐	☐
E. Poorly Lighted	☐	☐	☐
F. High Noise	☐	☐	☐
G. Overcrowded	☐	☐	☐
H. Tight Restricting Areas	☐	☐	☐

ABILITY TO LIFT AND CARRY

3. Check the category most appropriate for the Patient's current condition:

☐ Sedentary Work – Lift up to 10 pounds with occasional walking, standing, or carrying.

☐ Light Work – Lift up to 20 pounds with frequent walking, standing and carrying objects up to 10 pounds.

☐ Medium Work – Lift up to 30 pounds with frequency including walking, standing, and carrying same.

☐ Full Duty Work – Extended lifting and moving of material up to 50 pounds.

OTHER INSTRUCTIONS AND/OR LIMITATIONS

4. Respond as appropriate for the Patient's current condition:

A. List currently prescribed medications including name, dosage, periodicity, etc.

B. Is the Patient's diet a factor?_____

If so, describe dietary requirements _____

_____

_____

_____

C. Could the Patient faint or otherwise lose consciousness at the workplace as the result of the current medical condition? _____

_____

_____

D. Can the Patient's current condition cause significant risk to the health or safety of the Patient in the workplace?

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To others working with him/her? _____

If so, How can this risk be mitigated? _____

E. Does the Patient's current condition include any mental/emotional considerations which the employer should attempt to accommodate (Explain)? _____

F. Additional Advice/Comments? _____

DISPOSITION / ADVICE

5. ☐ Any restrictions or limitations herein are in effect until (date) _____ or until the Patient is re-evaluated on (date) _____.

☐ Patient is not able to Return to Work at this time – Patient will be re-evaluated on (date) _____.

☐ Patient is being referred to _____ for purpose of _____

I will ☐ will not ☐ remain as Patient's Primary Physician of Record.

Medical Provider Name (Printed) _____

Medical Provider Signature _____ Date _____

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PATIENT AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE MY Attending Physician and/or hospital to release any information, or copies thereof, acquired in the course of my examination or treatment to my employer and/or his representative.

Patient's Signature _____ Date _____

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MANCON DRUG SCREEN PANEL

All on-the-job injuries or other accidents MUST be reported IMMEDIATELY to a MANCON SUPERVISOR or MANAGER and an accident report MUST be filled out.

MANCON requires drug screens when injuries, illnesses, or incidents occur in or as a result of the workplace. The following Drug Screen Location is provided for your reference to obtain the screen.

Drug Screen Location

Site Name	
Site Full Address	
Site Phone Number	
Site Fax Number	
Site Contact Person	
Drug Screen Hours	

Medical Treatment Location

If you received a Physician Panel in the packet of Workers Compensation Information, please review that panel for information regarding where you must seek treatment for this claim. If you did not receive a panel in your packet, you may choose your medical provider in accordance with the applicable state regulations.

Site Name	
Site Full Address	
Site Phone Number	
Site Fax Number	
Site Contact Person	
Medical Attn Hours	

☐ I have selected the above identified facility to administer medical treatment for my potential worker's compensation claim.

☐ I have chosen not to seek medical treatment for my workplace injury. I understand that if I feel the need to seek medical treatment for this incident at a later time, I may do so by visiting one of the above approved medical facilities. It is my responsibility to inform MANCON Corporate – Worker's Comp – at (757) 457-9312 if/when I seek medical treatment.

☐ I do not want to claim an injury at this time.

_____ _____
Signature Date

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