

STAFFORD DEVELOPMENT COMPANY

INCIDENT REPORT PACKET

Please fill out all forms and page Julie Bullington immediately when the incident occurs. The pager number listed below is the primary contact for WC Injuries. If Julie is on vacation or unavailable, she will pass the pager off to the next secondary contact.

Pager #: (877) 605-6760

Alternate Phone#'s:

Work Phone #: (229) 386-0552

Cell Phone #: (229) 392-5084

FAX to: Julie Bullington (229) 382-7671

1. Supervisor's Incident & Injury Report
2. Employee's Incident & Injury Report
3. Authorization for Release of Medical Records
4. Consent for Alcohol/Drug Test

Injured Employee should be sent to Physician on Pink Panel with the following:

1. Authorization for Testing
2. Doctor's Report of Injury (to be returned to Julie after Doctors visit)

File First Report of Injury with Insurance Company as soon as possible (mandatory within first 12 hours). Use toll free number 1-888-951-3200. Our policy # is WC2-151-277787-157.

Please take the time to fill these out completely and accurately answering all questions.

Mistakes can be very COSTLY!

Copies of ALL reports should be faxed to Julie Bullington within 24 hours of accident.
Updated 4/1/07

Company: _____

Date/Time: _____

EMPLOYEE INCIDENT REPORT

Incident **With** Injury: _____

Incident **Without** Injury: _____

Near Miss: _____

Employee Name: _____

Home Phone: _____

Address: _____

SSN#: _____

City: _____

Date of Birth: _____

State, Zip: _____

Sex: (circle) MALE/FEMALE

Job Title: _____

Department: _____

Shift: _____

Supervisor: _____

Location: _____

Status of Injury: First Aid Only () Doctor's Case () Drug Test () Medical Release Signed ()

Doctor's Report Sent () Supervisor Notified ()

First Aid Given By: _____

Location of Incident: _____

Date of Incident: _____ Date Reported: _____

Time of Incident: _____ (AM , PM) Time Notified: _____ (AM , PM)

Body Part Injured: _____

Description of How Incident &/Or Injury Occurred: _____

What Caused The Incident/Injury? _____

Employee Recommended Prevention: _____

Witnesses Names: _____

Employee Signature: _____

Report Completed by: _____

*Please have the
employee take the
attached four forms
with them for
treatment.*

Thank you

STAFFORD DEVELOPMENT COMPANY
WORKERS' COMPENSATION
CONSENT FOR ALCOHOL/DRUG TEST
(Post Incident/Injury)

I hereby voluntarily consent to participate in a controlled substance (Alcohol/Drug) test as part of my Post Incident / Injury medical examination.

I understand that refusal to submit to said test may result in denial of Workers' Compensation benefits and jeopardize the status of my employment.

I further give my consent to release to Stafford Development Company or designated agency, the results of the alcohol/drug test performed by any designated facility.

I understand that the results of this test shall remain confidential.

Print Employee Name

Signature of Employee

Witness

Date

Date

STAFFORD DEVELOPMENT COMPANY
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO WHOM IT MAY CONCERN:

I, _____ hereby authorize any and all physicians and hospital facilities, my private hospitals, physicians, and any of my other medical providers to furnish any and all of my medical records to the Workers' Compensation Coordinator Stafford Development Company, P.O. Box 269, Tifton, Georgia 31793, or any representative, of said Company to obtain said records which are requested by said representative. This authorization includes, but is not limited to; the release of all of my hospital records, x-rays, mental health records, and information which will aid said representative in the evaluation of my medical condition.

You are further authorized to permit said representative or the bearer of this Authorization (or a copy thereof) to review any hospital, medical, mental health or other records relating to my medical condition and to furnish copies of said records to said representative. I expressly authorize and request your full cooperation with said representative in providing a full disclosure of all information within your control and possession relating to my medical treatment.

This _____ day of _____, _____

Employee Signature _____

Social Security Number _____

Witness _____

STAFFORD DEVELOPMENT COMPANY

Authorization for Testing

Stafford Development Company authorizes the following to be performed on:

Name: _____
 Last First MI

SS#: _____

Reason for Testing:

- | | |
|---|--|
| <input type="checkbox"/> Pre-Employment Drug Test | <input type="checkbox"/> Pre-Employment Breath Alcohol |
| <input type="checkbox"/> Random Drug Test | <input type="checkbox"/> Random Breath Alcohol |
| <input type="checkbox"/> Post-Incident Drug Test | <input type="checkbox"/> Post-Incident Breath Alcohol |
| <input type="checkbox"/> Reasonable Suspicion Drug Test | <input type="checkbox"/> Reasonable Suspicion Breath Alcohol |
| <input type="checkbox"/> PFT-Pulmonary Function Test | _____ |
| <input type="checkbox"/> Industrial Physical Exam | <input type="checkbox"/> DOT Physical Exam |

Other: _____

Authorized Signature

Date

Fax Correspondence in confidence to.-
Stafford Development Company
229-382-7671

STAFFORD DEVELOPMENT COMPANY
DOCTOR'S REPORT OF INJURY

To: _____

_____ was injured while performing
work on _____, _____.

**Please treat this employee and send all Workers, Compensation medical forms and
correspondence to the following:**

STAFFORD DEVELOPMENT COMPANY
P.O. Box 269
Tifton, GA 31793

Please complete the following:

I treated the above named employee on ___ / ___ / ___ at _____ AM/PM.

A. The employee will be able to return to REGULAR DUTY work on ___ / ___ / ___.

B. The employee will be able to return to LIGHT DUTY work on ___ / ___ / ___ with
the following restrictions. _____

C. The employee will not be able to work at this time.

D. I will see the employee again on ___ / ___ / ___ at _____ AM/PM.

E. Medical Findings:

F. Medications Prescribed:

Physician's Signature

Date

Physician's Name (Please Print or Type)

Physician's Address

Please have the Injured employee take this with them for treatment.