

## PCMI WORKERS COMPENSATION PROCESS

When a PCMI employee is injured while on assignment, the following process should be followed to ensure the employee receives immediate care when medically necessary and any/all follow up treatment is managed in a timely manner.

- **All** injuries for PCMI employees must be reported utilizing the **PCMI Accident Report** (attached). This includes minor injuries that do not require medical treatment (example: small cuts, bruises, sprains, etc)
- All injuries must be recorded at the time the injury occurs (unless life threatening) and documented on the PCMI Accident Report, in addition to any district report that is completed.
- For minor injuries that do not require medical treatment, the PCMI Accident Report should be completed at the time of the injury and faxed directly to the PCMI Workers Compensation Representative.
- For injuries that require immediate medical attention/life threatening, the PCMI Accident Report should be completed as soon as possible and the employee should be sent for medical treatment to the nearest company approved medical facility. A copy of the **Authorization for Medical Treatment Form**, should accompany the employee (attached). For **any** medical emergency requiring immediate treatment, including EMS and/or hospitalization, contact should be made immediately, by telephone, to the PCMI Workers Compensation Representative to report the injury, in addition to completion of the PCMI Accident Report.
- Injured PCMI employees who require medical attention should be directed to the health care provider the district uses for medical treatment.
- To request additional forms or for any questions related to the PCMI Workers Compensation Process, please refer to the contact information provided below:

### **PCMI Contact Information:**

Human Resources Generalist II  
Mary DePue-Witgen  
PO Box 516  
Portland, MI  
Phone (517) 647-5243  
Fax: (517) 647-5257

Human Resource Director:  
Stephanie Peters  
PO Box 516  
Portland, MI  
Phone: (517) 647-7533  
Fax: (517) 647-7535



# PCMI Employee Accident Report

**Fax to Mary DePue-Witgen at 517-647-5257**

Please print clearly and complete all sections of the accident report.

Person involved in incident: \_\_\_\_\_  
Last Name First Name Middle Name

Worker's Occupation: \_\_\_\_\_ Worker's Location: \_\_\_\_\_

Street Address Apt#/PO Box City State Zip

Primary Phone (include area code) Secondary Phone (include area code)

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 Accident Occurred: \_\_\_\_\_

Address Where Accident Occurred City State Zip

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

Was there an unsafe condition that caused the injury? (circle one): yes no If yes, please list the unsafe condition

that caused the injury: \_\_\_\_\_

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 accident occurred? (circle one) yes no If no, explain: \_\_\_\_\_

Medical Treatment Required? \_\_\_\_\_ None \_\_\_\_\_ First Aid \_\_\_\_\_ 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.

**PCMI AUTHORIZATION FOR TREATMENT**

Date: \_\_\_\_\_

**PCMI authorizes the medical facility and/or doctor to render necessary treatment and to injured employee:**

Who alleges a work related injury occurred on (date of injury): \_\_\_\_\_

Nature of injury:

Date of birth: \_\_\_\_\_ Soc Sec Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ PO Box/Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone (primary): \_\_\_\_\_ (secondary): \_\_\_\_\_

e-mail: \_\_\_\_\_

Medical Facility/Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature (ie District Supervisor)

\_\_\_\_\_  
Title

**All bills should be directed to:  
Accident Fund Insurance Company  
PO Box 40790  
Lansing, MI 48901-7990  
Fax: 517-3162747  
Policy Number: WCV6051238**

**All additional information should be directed to:  
PCMI  
Mary DePue-Witgen  
Phone: 517-647-5243  
Fax: 517-647-5257  
e-mail: marydw@pcmiservices.com**