SATILLA RURAL ELECTRIC MEMBERSHIP CORP.
EMPLOYEE ACCIDENT/INJURY INVESTIGATION FORM

FORM - 400A

Instructions:

For use in reporting **all employee **minor** or **major** injuries.*

+Use graph paper from Accident Investigation Kit to draw detailed diagram of accident scene, if necessary, including: _temperature _line height _voltage _position of objects _measurements -- and attach diagram to this form.

+Take photographs of the scene from the front, back, and both sides.

+Document all evidence that is likely to be removed, rained out or lost.

REPORTING DATE: ________/________/________

Employee Name: ____________________ D.L. #: ____________

Address: ____________________ S.S. #: ____-____-____

Job Title: ____________ Date of Employment: ________ Department: ________

Date of Birth: ____________ Age: ________ Sex: Male ______ Female ______

WHERE did the accident happen?

LOCATION: ______________________________ Satilla Map Number: ____________

(Give complete address including county in which the accident occurred)

WHEN did it happen? ________ a.m. ________ p.m. Date: ____/____/____

What time employee reported to work on the day of the injury? ____________

WEATHER: Clear ______ Cloudy ______ Rainy ______ Fog ______ Ice ______ **TEMPERATURE:** ________

WHO was involved? (Include names, address, phone numbers, if not employed by Satilla REMC.)

Name:	Name:	Name:
Address:	Address:	Address
City/St/Zip:	City/St/Zip:	City/St/Zip:
Phone:	Phone:	Phone:
Medical Treatment: YES NO	Medical Treatment: YES NO	Medical Treatment: YES NO
Describe Injury:	Describe Injury:	Describe Injury:
Medical Facility:	Medical Facility:	Medical Facility:
Doctor/EMS:	Doctor/EMS:	Doctor/EMS:
Fatality: YES NO	Fatality: YES NO	Fatality: YES NO
(Use additional forms if more than three victims involved.)		

(Draw diagram of accident scene and attach to form if necessary.)

HOW DID IT HAPPEN? (Describe cause of accident; include any item or conditions that may have contributed to the accident/injury.)

____

____

____

-OVER-

WHAT HAPPENED? (Describe in detail. Example: John fell while climbing company ladder to tie in electric service and broke his right ankle.)

____

____

____

DIRECT CAUSE: (unsafe act that brought about the accident) ______________________

____

____

INDIRECT CAUSES: (unsafe acts or conditions that relate to the direct cause) ______________

____

____

SAFETY RULE VIOLATIONS: ____

____

WITNESSES: (BEFORE, DURING OR AFTER) (Give names, addresses and phone numbers.)

(1) Name: ______________________ **(2)** Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

State: __________ Zip: ______ State: __________ Zip: __________

Phone: ( ) ______________________ Phone: ( ) ______________________

(3) Name: ______________________ **(4)** Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

State: __________ Zip: ______ State: __________ Zip: __________

Phone: ( ) ______________________ Phone: ( ) ______________________

(Get individual written or recorded statements and ask them to sign and date, if possible.)

CONCLUSIONS/RECOMMENDATIONS/CORRECTIVE ACTION NEEDED:

____

____

____

____

Employee Signature: ______________________________ Date: _____/_____/_____

Supervisor Signature:______________________________ Date: _____/_____/_____

Reviewed by Safety Committee: ______________________________________

Reviewed by President/CEO: ____

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

Instructions: **This form shall not be filed with the Board, unless otherwise requested**

TO:		
Print Name and Title		
Address		
City	State	Zip Code

RE: Employee / Patient		
Last Name	First Name	M.I.
SSN or Board Tracking #	Date of Injury	Birthdate

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to Georgia Administrative Services in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. !34-9-207 which reads as follows:

(a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee.

(b) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

(c) If the employee refuses to provide a signed release for medical information as required by this Code section and, in the opinion of the Board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim.

Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 45 CFR 164.512(1) which reads as follows: "The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault." Anyone who receives information under this authorization receives the same under all limitations set forth in Federal and State law regarding further dissemination of such information.

This release shall expire in 180 days or upon written notice of revocation by the patient. If a hearing is pending, this release shall remain in effect until the hearing and shall expire on the date the hearing is held.

Employee / Patient Signature	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. !34-9-18 AND !34-9-19).

<u>AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION INJURED WORKERS' MEDICAL RECORDS AND INFORMATION FROM INJURED WORKERS' TREATING PHYSICIANS</u>

I ___________________ __, ____________________, do hereby authorize *Georgia Administrative*
(injured worker) (date of birth)

Services, Inc. and their agents, attorneys, administrators, third-party vendors and representatives assisting employer and *Georgia Administrative Services, Inc.* in handling or investigating my workers' compensation claim, to request, obtain, and review any and all documents, bills, office notes, medical records, reports, test results, correspondence, memos, e-mails, x-ray, MRI or CT films or any other diagnostic imagery, or any other record of any kind relating to the medical history, treatment, admission, care, billing and communication of the Injured Worker. This authority expressly extends to and includes authorization to conduct verbal communications with any of the Injured Workers' physicians, surgeons, nurses, chiropractors or any other treating medical personnel of any kind regarding the Claimant's medical care, prognosis, treatment, or condition. Any photostatic copy of this Medical Authorization shall be deemed valid as if it were an original.

I agree to release any entity, facility, office, hospital, and medical practitioner from any and all liability which may result or could result from the release of such information. This release is in compliance with Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 45 CFR 164.512(1) which reads as follows: *The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault.* Anyone who receives information under this document receives the same under all protection of Federal and State law inuring to the patient.

Injured Worker Signature___________________________________Date ______________

Employer Signature _____________________________________ Date _______________