



## INJURY REPORT CHECKLIST

**Please Fax completed form to (904) 262-2760; Attention: Risk Management Dept.**

CLIENT COMPANY: \_\_\_\_\_ LOCATION: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

PERSON COMPLETING CHECKLIST: \_\_\_\_\_ ACCIDENT DATE: \_\_\_\_\_

1. Did you get statements from the injured employee, witness (es), and supervisor regarding the extent of the injury?  Yes  No  
(You may wait and follow up later with item 1 if the injury is severe and the employee requires immediate care.)
2. Did you contact Matrix Employee Leasing with information about the accident/injury immediately after the accident?  Yes  No  
If no, why not? \_\_\_\_\_
3. Was the injured employee taken or directed to a medical provider authorized by Matrix Employee Leasing?  Yes  No
4. Did anyone accompany the injured employee to the medical treatment facility?  Yes  No
5. Was the medical provider informed that Matrix Employee Leasing is the employer of record?  Yes  No
6. Was the medical provider instructed to mail medical reports, bills, and all documentation to Matrix Employee Leasing?  Yes  No
7. Was the employee screened for drugs?  Yes  No
8. Did the injured employee sign the accident/injury report form?  Yes  No
9. Did you speak with the injured employee after the accident to let him/her know your concern and desire to have him/her back to work as soon as possible?  Yes  No
10. Did you send copies of information you received from the doctor to Matrix Employee Leasing?  Yes  No
11. Have you started a file on this accident?  Yes  No
12. Has time been lost due to this injury?  Yes  No
13. If the employee declined medical treatment and did not satisfy the drug screening requirements, did he/she sign the proper forms associated with his/her declination of treatment?  Yes  No
14. Did you obtain all of the names, contact numbers, and statements from the witness (es)?  Yes  No
15. Have you checked the accident area and equipment used to determine if it was user error or equipment failure?  Yes  No
16. Have you taken any measures to prevent this accident from occurring again?  Yes  No
17. Have you determined whether proper safety rules were followed or in use at the time of accident?  Yes  No

\_\_\_\_\_  
(Printed Name of Person Completing Form)

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

\_\_\_\_\_  
(Signature of Person Completing Form)

### **MATRIX EMPLOYEE LEASING**

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Jacksonville, Florida 32256

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