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| **Your Logo and School Name Here**  Your School Address and Contact Information Here | | In case of a workplace injury:  **WORKER GRAB ‘N GO KIT**  An essential part of our Return-to-Work Program |
| **EMPLOYEE INSTRUCTIONS:**  This Worker Grab ‘N Go Kit is designed to facilitate the workers’ compensation process in the event of a workplace injury. The five documents listed below are contained in this kit. This envelope and its contents should be taken to your medical appointments and given to your treating health care provider. Please review all contents and follow the directions written next to each document listed. | | |
| **Documents #1, #2, #3, #4 are informational for your provider. Originals are to be returned to our workers’ comp designee.** | | |
|  | 1. **Notice of Accident** – To be completed by you as soon as possible after the incident. Once you return the completed form to your employer, you will get a copy you can show to your treating health care provider, if the provider requests a copy. | |
|  | 1. **Worker’s Authorization for Use and Disclosure of Health Records** – To be completed by you as soon as possible after the incident. Show this to your treating health care provider so they can release appropriate medical records to authorized parties. | |
|  | 1. **Cover Letter to Treating Health Care Provider** – Informational letter to your treating health care provider explaining our company’s Return-to-Work Program. You do not need to return this as it is information your provider can keep on file. | |
|  | 1. **Job Description** – Not included with this packet. Human Resources will provide when required. | |
| **Document #5 is to be filled out by your treating health care provider at your initial visit and at each follow-up appointment.**   * **Return the completed Provider’s Report of Physical Ability to our workers’ compensation contact.** | | |
|  | 1. **Provider’s Report of Physical Ability** – At your initial visit and each of your follow-up appointments, ask your treating health care provider to complete this form and give it to you. Return the completed Provider’s Report of Physical Ability to our workers’ compensation contact as soon as possible after each of your appointments. | |
| For any questions, please contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(*workers’ comp contact*) at phone# \_\_\_\_\_\_\_\_\_ or email at \_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Thank you for cooperating with our efforts to maintain a safe, healthy, and productive work environment for all our employees.** | | |