



# City of Traverse City Injury Report

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are not requesting or requiring you to disclose any genetic information on this form. Therefore please do not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**TO BE COMPLETED BY EMPLOYEE:**

**Please Print**

1. Name \_\_\_\_\_ 2. Birthdate \_\_\_\_\_  
(Last) (First) (Middle)

3. Home Address \_\_\_\_\_ 4. \_\_\_\_\_  
(# and Street) (HOME phone #)

\_\_\_\_\_ 5. Marital Status: M \_\_\_ S \_\_\_  
(City) (State) (Zip Code)

6. Job Classification \_\_\_\_\_ 7. Time Employee Begins Work \_\_\_\_\_

8. Date of Injury \_\_\_\_\_ 9. Time of Injury \_\_\_\_\_ 10. Witnessed By \_\_\_\_\_

11. What Kind of Injury? (Contusion, cut, fracture, sprain, strain, etc.) \_\_\_\_\_

12. Body Part Injured (left leg, right arm, back, etc.) \_\_\_\_\_

13. How Did Injury Occur? \_\_\_\_\_

14. Where Did The Injury Occur? (location) \_\_\_\_\_

15. Injury Reported To \_\_\_\_\_ 16. Time \_\_\_\_\_ 17. Date \_\_\_\_\_  
(Supervisor)

18. Is This A Re-injury? \_\_\_\_\_ 19. Date of Original Injury? \_\_\_\_ 20. Reported to Employer? Yes \_\_\_ No \_\_\_

Other Employment: 21. Do You Have Any Other Jobs (or are you self-employed)? Yes \_\_\_ No \_\_\_

22. If Yes, Name of That Employer \_\_\_\_\_

23. Are you Losing Time From That Job? Yes \_\_\_ No \_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_



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### **TO BE COMPLETED BY SUPERVISOR:**

**Please Print**

24. Injured Employee's Name \_\_\_\_\_

25. Is the Date, Time, and Location of the Injury Correct? Yes \_\_\_\_ No \_\_\_\_ (If No, please explain with accurate facts)

26. Was the Employee Sent for Medical Treatment? Yes \_\_\_\_ No \_\_\_\_

Where? \_\_\_\_\_ What Time? \_\_\_\_\_

27. Has the Employee Returned To Work? Yes \_\_\_\_ No \_\_\_\_ (If Yes, what date and time did the employee return?)

28. Why did this Injury Occur? \_\_\_\_\_

29. What Corrective Actions Have You Taken to Prevent Reoccurrence of this Type of Injury? \_\_\_\_\_

Other Employment or Outside Activities:

27. Does this Employee Have Another Job (or are they self-employed) Yes \_\_\_\_ No \_\_\_\_

If yes, with whom? \_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

## City of Traverse City Medical Authorization

From: City of Traverse City  
400 Boardman Avenue  
Traverse City, MI 49684

Attn: Kristine Bosley  
Human Resources Generalist  
PHONE 231.922.4481 FAX: 231.922.4470

1. Employee's Name \_\_\_\_\_ 2. Date \_\_\_\_\_  
3. Job Classification \_\_\_\_\_ 4. Date of Injury \_\_\_\_\_  
5. Description of Injury or Problem \_\_\_\_\_  
\_\_\_\_\_

Signature of Person Authorizing Medical Treatment \_\_\_\_\_

### The following Section is to Be Completed by the Physician

**Doctor's Report:** Please fill in the information below completely and have the employee return the completed form to his/her supervisor immediately following this treatment.

6. Diagnosis \_\_\_\_\_  
7. Treatment Rendered \_\_\_\_\_  
8. Is Further Treatment Necessary? Yes \_\_\_\_ No \_\_\_\_ If yes, what type? \_\_\_\_\_  
\_\_\_\_\_
9. Referred to Another Physician? Yes \_\_\_\_ No \_\_\_\_ Who? \_\_\_\_\_
10. Medication Prescribed? Yes \_\_\_\_ No \_\_\_\_ What and What Are the Restrictions Associated with the Medication(s)?  
\_\_\_\_\_
11. Employee May Return To Work as Follows: \_\_\_\_\_ Today, No Restrictions  
(See supervisor for limited work availability) \_\_\_\_\_ Today, With Restrictions as Indicated Below  
\_\_\_\_\_ Tomorrow, No Restrictions  
\_\_\_\_\_ Tomorrow, With Restrictions as Indicated Below  
\_\_\_\_\_ Other, Please Specify \_\_\_\_\_

Restrictions \_\_\_\_\_

Date \_\_\_\_\_ Doctor Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

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