# 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 Title _____ 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 _____



Revised 09-2015

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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_____



Revised 09-2015

# City of Traverse City
# Medical Authorization

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

Attn: Human Resources Department
PHONE 231.922.4481
FAX: 231.922.4470

1. Employee's Name _____ 2. Date _____

3. Job Title _____ 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:
(*See supervisor for limited work availability*)

_____ Today, No Restrictions
_____ 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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