



9393 Mill Springs Drive, Jacksonville, Florida 32257
Telephone (904) 731-9014 Fax (904) 731-0059
Hours M-F 8 to 5 PM EST
www.ConvergenceEmployeeLeasing.com

Convergence Employee Leasing, Inc. is dedicated to creating a safer work environment for you and your staff. Our focus is on loss prevention services. Including preventative practices, safety meetings, compliance posters, and video training. Please be sure to read over our Workers' Compensation information and the reporting procedures contained in this packet. It is important to report all Workers' Compensation claims as soon as possible, *no matter how minor the incident*. Pursuant to Convergence's policy, all injured employees must undergo a Post-Injury Drug Test within 24 hours of the injury. If claims are not reported timely, as discussed here, fines assessed by the State of Florida – Division of Workers' Compensation will be passed to you as the client.

Step #1 Report Accident Immediately

Convergence Employee Leasing (904) 731-9014
After Hours/Weekend (904) 302-2666

Note this number is for new WC claim reporting only. All other inquiries will need to go through our main line listed above during our normal hours of operation.

Step #2 Medical Treatments for Injuries

Convergence will coordinate the initial medical treatment & drug testing for the injured employee with an authorized medical provider. If the injury is life threatening, please seek treatment at the closest hospital or call 911 immediately. All employees with a work-related injury must submit to a post-accident drug test at the time of initial medical treatment. Failure or refusal to submit to drug testing could jeopardize workers' compensation benefits. A photo ID will be required at the medical provider location.

Step #3 Fax or Email Completed Reports

Complete the enclosed documents in this Accident Packet within 24 hours of the accident.

We appreciate your business and look forward to working with you. Please contact us with any questions or concerns.

Risk Administration Team

Kayleigh Faulk
Risk Administrator
KFaulk@ConvergencePEO.com
(904) 731-9014

Don Newman
Safety Coordinator
DNewman@ConvergencePEO.com
(904) 603-2393

Adrienne Garcia
Bilingual & Afterhours Risk
Administrator
Claims@ConvergencePEO.com
(904) 302-2666

Return completed forms within 24 hours
Fax: (904) 731-0059 or Email: claims@convergencepeo.com



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Accident Investigation Report

Client Company Information

Client Name: _____ Phone: _____
 Office Address: _____ City: _____ St: _____ Zip: _____

Employee Information

Employee's Full Name: _____
 SSN: _____ Date of Birth: _____ Phone: _____
 Street Address: _____ City: _____ St: _____ Zip: _____
 Job Title: _____ Date of Hire: _____ Rate of Pay: _____

Accident Details (Attach additional documentation if necessary)

Date of Accident: _____ Time of Accident: _____ AM PM
 Date and Time Accident was Reported to Management: _____ AM PM
 Date and Time Accident was Reported to Convergence: _____ AM PM
 Last Date Worked: _____
 Address where accident occurred: _____
 Describe injuries that occurred: _____ Body part(s) injured: _____
 Did the injury occur on client company premises? Yes No
 Facility providing treatment: _____ Facility Phone: _____
 Address of facility: _____
 Did anyone witness your accident? Yes No If yes, please list their name(s) below.

Signature of Worker **Date**
 Signature of Worker unavailable

Signature of Supervisor **Date**

DWC25, Chain of Custody drug screen form from your initial treatment & any MVA documentation must be submitted to Convergence within 24 hours.

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Supervisor's Report of Injury

Employee Information

Employee's Name: _____ SSN: _____

Job Title: _____ Date of Hire: _____ Rate of Pay: _____

Accident Details (Attach additional documentation if necessary)

Date of Accident: _____ Time of Accident: _____ AM PM

Address where accident occurred: _____

Describe injuries that occurred: _____ Body part(s) injured: _____

Were there any witnesses? Yes No If yes, furnish names, addresses and phone numbers:

Cause of Accident

Time employee began work on date of accident: _____ AM PM

How did the accident happen? _____

Specify machine, tool or object most closely connected with accident: _____

What was the employee doing when the accident occurred? _____

If the accident was caused by another person not within the company, give name, address & phone number:

Could this accident have been drug or alcohol related? Yes No

Did the employee seek treatment after accident? Yes No Was employee drug tested after accident? Yes No

If NO, explain why. *(It is mandatory that all injured employees be drug tested after an accident).*

If validity of this claim is doubted, state reason: _____

Can a light duty position be accommodated? Yes No

Has employee returned to work? Yes No If yes, indicate date returned to work: _____

Client Name & Phone

 Print Name of Supervisor

 Signature of Supervisor

 Date



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Physical Demands Form of Pre-Injury

Client's Name: _____ Name of the person completing this form: _____

Employee's Name: _____ SSN: _____

Employee's Normal Work Schedule: _____ Employee's Job Title: _____

Brief Summary of Job Duties: _____

	Constant	Frequently	Occasionally	Not at all
Lifts and/or carries items? Normal Weight Range?				
Bend				
Climb				
Crawl				
Grasp				
Kneel				
Push/Pull				
Reach				
Sit				
Squat				
Turn/Twist				
Walk				
Pinch				
Wrist Turning				
Repetitive Motion				
Use of Vibratory Tool(s)				

Environmental Conditions	Yes/No/Both
Is the majority of work performed inside or outside? Or Both?	
Temperature Extremes?	
Fumes?	
Dust?	
Gases?	
Odors?	
Mist?	
Noise?	
Vibrations?	

Please name any specific hazards:	
Specific machines/tools/equipment used:	

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Refusal to File a Workers' Compensation Claim

I, _____ (Worker's name), with a social security number of _____
 (Social Security number or drivers' license/state identification card number if the Worker cannot remember their Social Security Number), have reported an accident, or an accident has been reported on my behalf, that may have occurred in the course of my employment on _____.

I have been offered medical care and treatment after the accident by my supervisor _____
 (Name of the representative who has offered the Worker medical care) which I specifically have refused.

I have refused all medical care since it is my belief that I am not injured and thus I do not require any medical care or treatment. As such it is my intention that this matter not be pursued as a workers' compensation claim and I hereby waive my eligibility to receive any workers' compensation benefits related to this accident.

I further acknowledge that at the time of my hiring I signed a document consenting to take a post-accident drug test that I agree that I have read and understood. In that document I acknowledged and agreed that if I was ever injured at work that I would immediately undergo a post-accident drug test.

I understand that although I have refused to accept any medical care or potential workers' compensation benefits that I may be eligible for that I am still required to immediately undergo a post-accident drug test.

I have spoken with my supervisor who has specifically instructed me to go to _____
 (Name of facility) where I was to provide a sample for a drug test.

Please **initial** the correct answer below:

_____ I confirm that I am taking the drug test and will complete it within 24 hours.

_____ I confirm that I have refused that test because I am not injured.

_____	_____	_____
Signature of Worker	Date	Printed name of Worker

Supervisor Witness to refusal of workers' compensation benefits	Date	Printed Name

Date of Accident: _____ Time of Accident: _____ AM PM

Accident Description: _____

Time of drug test refusal: _____ AM PM

Body Parts Injured in Accident, if any (*Any answer here requires that a workers' compensation claim be immediately reported and the worker must undergo a drug test*): _____

Witnesses to Accident: _____



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Available Modified Duty Agreement

Convergence Employee Leasing, Inc. and your direct Employer are committed to providing their employees with the best possible care if you are injured on the job. Working alongside your direct Employer, Convergence has designed a program that allows you, as an injured worker, to return to work on a modified duty basis.

Modified duty accommodations are based upon those restrictions that are determined by your authorized treating physicians and the modified duty accommodation will be administered by your direct Employer.

According to our records, your authorized doctor has released you with the following restrictions as of: _____

These are the restrictions/limitations set by your authorized doctor:

This letter serves as notice that modified duty is available for within the above noted restrictions as of _____

and that you are expected to report to work on _____ at _____ AM PM.

Attached you will find your doctor's paperwork outlining your limitations.

Failure to report promptly for the scheduled assignment above will be marked as an unexcused absence, and you will not be paid for the days missed after that date and time. Failure to contact your supervisor in response to this letter will also be considered an unexcused absence. An unexcused absence can lead to the suspension of or even the termination of your workers' compensation benefits and loss of employment.

If you have any questions or concerns, please contact our Risk Administrator at (904)731-9014.

By signing below, I, _____ Accept Decline (please check only one) the modified duty offered.

Signature of Worker **Date**