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

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

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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 Supervisor** **Date**

☐ **Signature of Worker unavailable**

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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Refusal to Undergo Post-Accident Drug Test

- I am aware that Convergence Employee Leasing (Hereinafter Convergence) requires mandatory post-accident drug testing.
- I admit and agree that I have previously acknowledged, at the time of my completion of the employment application paperwork for Convergence, that I am required to undergo a mandatory post-accident drug test.
- I also admit and agree that I fully understand that if I refuse to undergo that drug test that I will be denied workers' compensation benefits pursuant to Florida Statute 440.09 (7) (c).
- I have spoken with my supervisor_____ (name of supervisor) on _____ at _____ ☐ AM ☐ PM (time of discussion) who has specifically advised me that I must take a post-accident drug test and has provided me with information as to where I am to go to take that test.
- Despite this I am refusing to undergo a post-accident drug test.
- That I am refusing to undergo a post-accident drug test voluntarily and of my own free will.
- That I understand that even if I possess a medical marijuana card that I am still required to undergo a post-accident drug test.
- I understand that if I do not undergo the post-accident drug test that Convergence reserves a right to terminate my employment.

My reason for refusing the drug test is (Please check correct answer or fill in your own answer):

☐ I do not believe that I have been injured at work.

☐ I did have an accident but that the injuries are so minor as to not require medical care. The specific injury(ies) are as follows: _____

☐ I am refusing to undergo mandatory post-accident drug test for some other reason not referenced above which is: _____

Regardless, I hereby acknowledge that I have knowingly and willingly refused to provide a sample for a drug test despite understanding that my workers' compensation claim will be denied because of that decision. I fully understand and agree that if I have been injured at work but refuse the mandatory post-accident drug test then I will be solely liable for paying for my own medical care and that I will not be paid for any lost time from work by Convergence or its workers' compensation insurance carrier.

_____ _____
Signature of Worker **Date** **Printed name of Worker**

_____ _____ _____
Witness to Worker Refusal of Medical Care/Drug Test **Date** **Time of Refusal**

Witness' Printed name: _____/Title_____

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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**

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