

To: All Districts
From: Edustaff HR Department
Re: Workers Comp Procedure for all Edustaff Employees

There are two forms an Edustaff employee needs if they are injured. The forms and procedure are explained below.

First Report of Injury: This form is TWO pages and we need both pages completed. It is vital that this form is filled out completely by both the school/location and the employee and then sent to Edustaff HR (either to humanresources@Edustaff.org or fax to 877-974-6339). This form allows us to start a claim with our worker's comp carrier, if treatment was sought. If there is not any treatment sought, we still need the form as we track all injuries. **Please do not submit the form until both pages are completed, mainly showing if they sought treatment and with the district signoff.**

Authorization to Treat: The employee will need to take this form with them to the medical facility if they seek treatment after an injury has occurred. This form has our phone number on it as well as the basic info of our worker's comp carrier for billing purposes. When this form is presented to the place of treatment they know to set it up as a work comp billing claim. We do not need this form sent to us, and if no treatment is being sought, the employee does not need this form either.

Where to treat: Please send our employees to the same medical facility as you send your employees, if you direct your employees care. Usually that is a Concentra or occupational health type of facility. Urgent Care is also an option if you don't have occupational health locations near you. They should not go to their own personal doctor, chiro, not the emergency room unless, of course, the injury dictates an ER visit.

Notification: We do not need to be notified immediately by phone from the employee or school location, as long as the first report of injury is filled out as completely as possible and sent to us as soon as possible. Please forward all medical bills, work notes, and any other medical paperwork to us when received.

If you have any questions on this procedure, please feel free to contact Julie Powers at 877-974-6338 ext. 1140.

Workers' Compensation Injury Checklist

Step 1: Confirm the Injury Date

- Injury occurred **on or after 12/8/25** → Use **AmTrust** forms
- Injury occurred **on or before 12/7/25** → Use **Accident Fund** forms

Step 2: Complete Required Forms

- First Report of Injury (FROI) – sent to Edustaff
- Authorization for Treatment – goes with injured employee to med facility
- Follow Workers' Compensation Procedure

Step 3: Complete the FROI (Both Pages Required)

- Page 1** fully completed
- Page 2** fully completed
- District information completed
- District signature completed (bottom of page two)

Step 4: Treatment Determination

- Employee is **NOT** seeking treatment
- Employee **IS** seeking treatment
 - Treatment location/provider documented on page two

⊘ Do not submit the FROI until treatment status is confirmed and the form is signed

Step 5: Treatment Guidance

- Employee understands treatment is **not required**
- If treatment is sought, employee is directed to the **district's designated provider**, if applicable by state

Step 6: Submit the FROI

- Both pages combined into **one single PDF**
- Submitted via **email** (preferred) humanresources@edustaff.org
- Faxed (acceptable if needed) 877-974-6339

Need Help?

Questions, feedback, or support reviewing this process with your team contact Julie Powers, Edustaff Benefits Manager at jpowers@edustaff.org or 877-974-6338 ext. 1140.

FIRST REPORT OF INJURY

Date of Report: ____/____/____

Date Notified Employer: ____/____/____

Date of Injury: ____/____/____ Time of Injury: ____:____ AM/PM (circle one)

Edustaff Employee Information:

Employee Name (Last, First, Middle): _____

SSN: _____ - _____ - _____ DOB: ____/____/____ Sex: M/F (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Phone Number: _____ - _____ - _____ Hire Date: ____/____/____

Job Title: _____

Injury Report Information:

Job/Injury Location: _____

DISTRICT: _____

Start Time: ____:____ AM/PM (circle one) End Time: ____:____ AM/PM (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Witness to Injury: _____ Witness Phone Number(s): _____ - _____ - _____

Explain How Injury Occurred: _____

Nature of Injury: _____

Part of the body directly affected by the injury: _____

Last Day Worked: ____/____/____

Was the injury fatal? Yes/No (circle one) If yes, date of fatality: ____/____/____



Did employee seek medical treatment? Yes/No (circle one) - **THIS MUST BE COMPLETED BEFORE SUBMITTING**

If yes, date of treatment: _____/_____/_____

Name of treatment facility: _____

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

District Information: **THIS MUST BE COMPLETED BEFORE SUBMITTING**

Building Supervisor: _____
(PRINTED NAME AND SIGNATURE)

Phone Number: _____ - _____ - _____

Date: _____

Feedback: _____

Please return BOTH COMPLETED PAGES via a single PDF attached to an email to Edustaff HR at humanresources@edustaff.org or via fax to 877-974-6339. Thank YOU!

AUTHORIZATION FOR TREATMENT Workers Compensation

This form authorizes a health care provider to treat the following Edustaff Employee:

for a work-related injury which occurred on _____

at _____.

Send all billing information to:

AmTrust Financial Services, Inc.

PO Box 89404

Cleveland, OH 44101

Policy# MWC1040642

If the bills need to be faxed, they can be faxed to 678-258-8395.

If any questions, please call 877-974-6338 ext. 140