

(to be completed by
Employee or designee)

MPS Employee Injury Follow-Up

Page 1 (instructions below)

1. Name: Click here to enter text.

Employee # XXXXX

2. Injury date: MM/DD/YY

3. Injury Location:

Choose
Enter room, area and/or
description

PART D

After Injury Follow-Up

4. Appointments, Restrictions, Follow-up (check all that apply)

Doctor Visit

No Visit Needed

If you do not see a doctor and symptoms get worse, please contact HR for instructions BEFORE making an appointment or seeing a doctor, unless it is an emergency. Then follow-up as soon as possible.

Doctor Appointments

Yes, Appointment Date:

MM/DD/YY

Doctor's Name & Address:

Results of appointment:

Please attach documentation of Aftercare instructions from the Dr's office. **YOU MUST PROVIDE A RETURN TO WORK FORM PRIOR TO RETURNING** fmla-wc@mpsomaha.org or fax to 402-715-1097 AND A COPY TO YOUR SUPERVISOR.

NOTE: Employees may not change Doctors after completing the Doctor's Choice form. Please notify HR with any change request.

Work Restrictions

No Work Restrictions

Notify Supervisor. No other action is required.

Work Restrictions Required

Please attach documentation of Work Restriction instructions from the Doctor's office

Follow-Up

No Follow-up

Appointment Needed
Notify Supervisor. No other action is required.

Follow-Up Appointment Scheduled, please list date:

MM/DD/YY

Please attach documentation of Work Restriction instructions from the Doctor's office

*Notify/update supervisor after EACH appointment

*This form should be completed within 48 hours of EACH appointment.

PART E

Lost Time

5. Please check the appropriate box for time missed (If other, please list details of lost time):

No Work Time Missed

Went home day of injury

1 work day missed

2 work days missed

3-4 work days missed

5-6 work days missed *

6-7 work days missed

8 days + work days missed

* 5 or more days missed and/or surgery scheduled, contact Human Resources for FMLA paperwork fmla-wc@mpsomaha.org

Comments:

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MPS Employee Injury Investigation Instructions

1. Injured employee's name -- FIRST NAME, M. INITIAL, LAST NAME and employee number (required)

2. Date the injury happened

3. Choose building or school name and enter the room or area where the injury occurred

PART D

After Injury Follow-up

4. Check the boxes that best describe the situation.
Please fill in the details.

PART E

Lost Time

5. Check the appropriate box. List comments, as needed. Be sure to contact fmla-wc@mpsomaha.org if 5 or more days of work is missed, will be missed or surgery is scheduled.

PLEASE COMPLETE THE ENTIRE FORM FOR EVERY DOCTOR VISIT AND
SAVE FILE & E-MAIL IT TO fmla-wc@mpsomaha.org OR FAX TO 402-715-1097