



Advance Service Company
5800 Monroe St. Bldg A
Sylvania, OH 43560
419-882-7646

On The Job Injury Procedure:

If an accident occurs at your job site with an Advance Service Company employee, our office must be contacted immediately. **Our office and 24 hour answering service is 419-882-7646.** Our employees are instructed to inform our office and their supervisor no matter how minor the injury may be.

Our employee should fill out our accident report regardless of necessary medical treatment. **An accident report must be completed within 48 hours of the incident.** Any witness to the accident should fill out a witness statement. The employee's supervisor should complete a supervisor report. **ASC must receive any and all information regarding injury.**

If medical attention is necessary, our preferred medical treatment facilities are:

OCC (East)
3028 Navarre Ave.
Oregon, OH
Open 8am-6pm, Mon. – Fri. & Sat. 8am-12pm

OCC (South)
7010 Spring Meadows
Holland, OH 43528
Open 8am-6pm, Mon. – Fri. & Sat. 8am-12pm

After hours, injuries are treated in the emergency room

However, if emergency medical treatment is necessary, our employee should go to the nearest Emergency Room. Please remind our employee that they work for ATSI, not your facility.

Employee must provide ASC with any documentation from the medical provider including medical restrictions and/or release to return to work PRIOR to returning to their job.

Encl.

Accident/Injury Report

Witness Statement

Supervisor's Accident Report

Medical Facility Map



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ACCIDENT REPORT

NAME _____ SS# _____
DATE OF INJURY OR EXPOSURE: _____ TIME: _____ (AM)(PM)
AGE: _____ SEX: _____ M _____ F _____ PHONE NUMBER: _____
OCCUPATION: _____ LENGTH OF JOB: _____
JOB SITE LOCATION: _____
DATE REPORTED: _____ TO WHOM: _____
EXACT LOCATION WHERE INJURY OCCURRED: _____
JOB OR ACTIVITY BEING PERFORMED AT TIME OF INCIDENT: _____

FOREMAN OR SUPERVISOR AT TIME OF INCIDENT: _____
NAMES OF ANY WITNESSES TO INCIDENT: (if none please specify) _____

DETAILED DESCRIPTION OF EXACTLY HOW INJURY OCCURRED: (if additional space is needed use back side of this form) _____

WHERE ARE YOU HAVING PAIN (be very specific): _____

WERE YOU OFFERED MEDICAL TREATMENT FOR THIS INJURY? _____
DID YOU REFUSE MEDICAL TREATMENT? _____ IF SO, WHY? _____

WERE YOU TREATED FOR THIS INJURY? _____ BY WHOM? _____
TYPE OF TREATMENT RECEIVED? _____

HAVE YOU EVER SEEN A DOCTOR FOR AN INJURY TO THIS PART OF YOUR BODY BEFORE? _____
IF SO WHERE? _____
DESCRIBE PREVIOUS INCIDENT/INJURY: _____

DO YOU WORK ANYWHERE OTHER THAN ADVANCE TEMPS? _____
IF SO, WHERE? _____
FAMILY PHYSICIANS NAMES & ADDRESS: _____

Signature of Employee

Date of this Report



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WITNESS STATEMENT

To be completed by Investigator:

Re: Employee: _____
Date & Time of Alleged Injury: _____
Part(s) of Body: _____

To be completed by Witness:

Your location at time of alleged injury: _____
Did you actually see the alleged injury: _____
What did you actually see: _____

Did you hear about the injury? _____
From Whom? Please explain: _____

Are you aware of any outside activities which may have contributed to this condition?

Are you aware of the individual having problems with this part of the body prior to or subsequent to this injury? Please explain: _____

Signature: _____ Date: _____
Printed Name: _____



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SUPERVISOR'S ACCIDENT REPORT

Employee Name: _____
Date of Injury: _____ Time of Injury: _____ AM or PM
Exact Location of Injury: _____
Date Reported to You: _____ By Whom: _____

Description of Injury: _____

Specific Body Parts Affected: _____

Was medical treatment sought? _____
Please explain: _____

Are you aware of any other activities this employee may be involved in? Please explain: _____

Has this employee had similar complaints previously? Please explain: _____

Co-Workers Interviewed (attach statements): _____

What corrective action was taken to prevent similar injury? _____

Supervisor Signature

Date

Print Name