CEG
NDACo COUNTY EMPLOYERS GROUP
WORK SMART – WORK SAFE

County Employer Group
Employee Post-Accident Procedure Form (C4)

Injured Worker's Name:	Date of Incident:
Social Security Number:	Date of Birth:
Supervisor:	Work Phone:

Complete this section for an accident with no medical treatment:

This accident (see attached report) has been reported as a near-miss only. I understand that if I seek medical attention for this accident, I am required to inform my Supervisor *and* Risk Manager prior to scheduling a medical appointment.

Employee Signature	Date	Phone
Supervisor Signature	Date	Phone

Complete this section for an accident requiring medical treatment:

- I understand that I must notify my Supervisor and Risk Manager prior to each medical appointment related to my work injury.
- I understand that I must bring back a completed copy of the North Dakota Workers Compensation C3 Form (Doctor's Report of Injury) to the Risk Manager immediately following each medical appointment.
- If I have been released to return to work with NO medical restrictions, I understand that if complications should arise and I need to seek medical attention for this work injury, I must contact my Supervisor *and* Risk Manager prior to scheduling a medical appointment.
- I understand that failure to comply with the above claims management procedures could jeopardize the payment of any Workers Compensation benefits I may be entitled to.

By signing this form the Employee and the Supervisor understand the procedures outlined above and have received a copy of this completed form. The employee has also received a supply of C3 forms.

Employee Signature	Date	Phone
Supervisor Signature	Date	Phone
Risk Manager Signature	Date	Phone