Your Right to Workers' Compensation

Getting hurt on the job can be devastating, which is why Educational Services, Inc. is committed to keeping you safe and healthy in the workplace. However, if you do get hurt or sick on the job, you are covered by CopperPoint Mutual Insurance Company.

What to Do if Hurt

1. **Inform your supervisor and ESI immediately.** If medical attention is necessary, go to the nearest urgent care facility. If a life-threatening injury has occurred, go to the nearest hospital.

2. **Complete the ESI Accident Report Form.** A copy of this form can be found online at EducationalServicesInc.com. You can also get a copy of this form by contacting Human Resources at payroll@esiaz.us or (844) 614-7784. Submission instructions are included on the form. When you submit the form, please include all medical documentation received upon treatment.

3. **Follow instructions for medical care.** There may be restrictions determined by our Workers' Compensation carrier regarding a personal physician you see about your injury. Educational Services, Inc. will let you know what requirements apply to you.

4. **Follow your physician’s instructions.** Your physician will determine when you are ready to return to work. If your physician will allow you to perform light duties and your district does not have a position for light duties, you must wait until you are fully released to begin working.

Please note if there is a delay in reporting the injury to ESI, payments for medical expenses may be delayed.
Accident Report Form

Copper Point Mutual Insurance Co. Policy #1002227

Employee Full Name: ________________________________
Employee SS#: ________________________________
Employee Birthdate: ________________________________
Employee Phone Number: ________________________________
Employee Address: ________________________________
Job Title: ________________________________

Start & End Time of Work Day: ________________________________

District: ________________________________
School Site: ________________________________

Address of Accident/Injury: ________________________________
Date of Accident/Injury: ________________________________
Time of Accident/Injury: ________________________________
Part of Body Injured: ________________________________
Nature of Accident/Injury: ________________________________

Will you seek medical attention for this accident/injury?  □ Yes  □ No
If yes, where?
(If medical treatment was necessary, please send all documentation immediately.)

Where did the accident/injury take place?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Describe how the accident/injury occurred:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
(Please indicate what job was being performed and what went wrong. Include any machine, tool, or object that was being used in connection with the accident.)

Please indicate how this type of accident can be prevented in the future (if at all):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Name(s) of Witness(es):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Copperpoint Mutual Insurance Company
3030 N. 3rd Street
Phoenix, AZ 85012

Please send completed form to payroll@esiaz.us
Phone: 480-719-3533