

# **Employee Accident**



## Employee Injury

When an employee has been injured, follow these steps:

1. Complete the [Employee Injury Report](#).
2. Have all witnesses present complete the [Employee Injury Witness Statement](#)
3. Complete the [Incident Investigation Report](#) (3 pages)
4. Complete the [Incident Investigation Report Supplemental Report](#) (2 pages)
5. Find a provider and report the incident to AmTRUST. Follow the instructions on the following page, "[Worker's Compensation Claim Reporting Information](#)". Make note of the claim number and write on the [Employee Injury Report form](#).
6. Send the employee to a medical provider in the network with a "[Provider Instruction Form](#)".
7. Report the Injury to the Manager immediately. If the Manager is not available, call the District Supervisor.
8. Scan and email all documents immediately to [tiffany.snider@smithdq.com](mailto:tiffany.snider@smithdq.com) and [marsha.parker@smithdq.com](mailto:marsha.parker@smithdq.com)
9. We cannot require an employee to seek medical treatment. If they refuse, it must be documented that they refused medical treatment. \*\*\*The paperwork for these injuries must be turned into HR. HR will determine if these will be submitted to the WC carrier. \*\*\*

**If the employee seeks medical attention, they must submit a work status report from the medical provider to be reviewed by HR before the employee is permitted to return to work**

**Policy Holder/Employer: DQ of Texas, Inc. (Smith Dairy Queens, LTD)**

**Policy number: SWC1602393 11/20/2025-11/19/2026**

# Workers' Compensation Claim Reporting Information



24/7 Toll Free Claim Reporting for All States

DQ of Texas Inc.  
Smith Dairy Queens, LTD.  
Policy number: SWC1602393  
11/20/2025-11/19/2026



(888)239-3909



[WorkersCompClaimReport@AmTrustgroup.com](mailto:WorkersCompClaimReport@AmTrustgroup.com)



[www.amtrustfinancial.com](http://www.amtrustfinancial.com)



## Information Required for All Claims Reported

1. Name of the insured and policy number
2. Name and contact information of injured worker
3. Date, time and place of accident
4. Description of accident or incident
5. Name, phone, and/or email of person making the report
6. Any information on the injured workers lost time

Early claim reporting is essential to a better claim outcome. Don't delay reporting if you do not have all the details.



## How do I help my injured worker find a doctor?

- We offer an online physician search for all states, [www.talispoint.com/amtrust/external](http://www.talispoint.com/amtrust/external)
- For California, [www.ly.talispoint.com/amtrust/campn](http://www.ly.talispoint.com/amtrust/campn)
- For CO, GA, PA & TN, please refer to the panel provided by AmTrust via mail or email



## How does my injured employee receive prescription medications related to the accident/injury?

- Refer to the claims kit for your state at [www.talispoint.com/amtrust/external](http://www.talispoint.com/amtrust/external) for a First Fill card for your injured employee to use at the pharmacy to cover the cost of approved medication.

## Timely Reporting

When a work-related injury occurs, it is important to act immediately. Timely reporting of a new claim helps to provide a smooth and successful claim process for both you and your injured worker.



### We're Here To Help

After your claim has been filed, we may be in touch to obtain additional information. Our goal is to offer a smooth and hassle-free experience – from your first contact to the claims conclusion. Feel free to also call us with any questions. We're here to help.



### Relax And Stay Positive

You have the assurance of our knowledge, expertise, and understanding of the claim process. We're with you all the way.



### Provider Instruction Form

*Please deliver to your provider at your first visit. (Por favor, entregue a su proveedor en su primera visita.)*

Dear Provider,

I am visiting your office for my injury treatment because my employer is contracted with the Coventry Worker' Comp Network through our insurance carrier. This workers' compensation network has been certified in accordance with the requirements of the Texas Department of Insurance. You are part of this network through your contract with either FOCUS Healthcare Management, First Health, Aetna or Coventry. Please use the information below as necessary for treatment coordination, referrals and communications.

**Responsible payor:**

AmTrust Financial  
P.O. Box 89453  
Cleveland, OH 44101  
Tel: (214) 360-8000  
Fax: (678) 258-8395

**To obtain a listing of procedures that require preauthorization:**

Call (800) 407-0704

**To request preauthorization:**

Call (800) 407-0704

**To obtain a listing of network specialists for referrals:**

Visit <https://www-sf.talispoint.com/amtrust/external/> or call (800) 937-6824

**Employee / Employer Information:**

Employee Name: \_\_\_\_\_

Employer Name: DQ of Texas, Inc. (Smith Dairy Queens, LTD.) POLICY #SWC1493029

Phone: 979-846-2222 X1109

Contact Name: Tiffany Snider, Director of Human Resources

***Please call us with our employee's medical/disability status after the initial visit.***  
This information is for identification purposes only. Payor liability for treatment and payment is governed solely by the provisions of the Texas Workers' Compensation Act. Please also refer to your Coventry Workers' Comp Network Provider Manual and your contract with FOCUS, First Health, Aetna or Coventry for other applicable provisions.

Coventry Workers' Comp Network  
Revised 03-2020

**Employee Injury Report**

Smith Dairy Queen Store: \_\_\_\_\_ Manager: \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_

**Injured:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_

Cell #: \_\_\_\_\_ TDL #: \_\_\_\_\_ Last 4 SS #: \_\_\_\_\_

Title/Occupation: \_\_\_\_\_ Work #: \_\_\_\_\_

Person to Notify (if child, list parent/guardian): \_\_\_\_\_

**Accident Facts:**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

**Location of Accident:** (Circle)

Parking lot   Restroom   Dining Room   Drive through   Other: \_\_\_\_\_

What was Employee doing at time of accident: \_\_\_\_\_

Physical description of injured: \_\_\_\_\_

**Medical Treatment:** (Circle)

First Aid   Physician   Ambulance   Hospital   Body part affected: \_\_\_\_\_

Type of First Aid Administered: \_\_\_\_\_

Medical Facility contacted? Yes / No   Date: \_\_\_\_\_ Time: \_\_\_\_\_

Method of transportation: \_\_\_\_\_

Name, Address, Phone # of driver: \_\_\_\_\_

List name, address, phone # for medical services below:

\_\_\_\_\_

Physician:

\_\_\_\_\_

Hospital:

\_\_\_\_\_

Ambulance:

**Statement of Injured:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Employee/Injured \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Signature of Manager/Supervisor \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

## Employee Injury Witness Statement

Fax Completed form to Smith Dairy Queens, LTD at 979-846-8618

Name of Witness \_\_\_\_\_ Phone # \_\_\_\_\_

Home Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Relationship to Injured (if applicable): \_\_\_\_\_

If no relation, reason in store/witnessed incident: \_\_\_\_\_

### Accident Facts:

**This statement concerns my knowledge of the alleged incident.**

Name of injured: \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Time of Incident \_\_\_\_\_ am/pm Dairy Queen location: \_\_\_\_\_

Please explain in detail what you know about this incident: (Name specific individuals, objects, or equipment)

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Did you actually see the incident? \_\_\_\_\_ If not, how did you hear about it? \_\_\_\_\_

Do you know of any other injury, incident or illness that this person has had? \_\_\_\_\_ If so, explain \_\_\_\_\_

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Additional information \_\_\_\_\_

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I CERTIFY the foregoing statements and answers on this form are complete and true, and that no information has been omitted.

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Signature

*Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.*

## Incident Investigation Report

First show concern and respond to the immediate needs of injured employee(s) (emotional, medical, notification of relatives, transportation, etc.). Once assured, complete your review at the incident scene as soon as possible. Show to all that the purpose of this review is not to assign blame, rather to ultimately prevent future incidents via a thorough review. Safely secure the scene. Be prepared as necessary to take photos, measure, sketch, gather evidence, refer to written standards, have witnesses complete written statements, etc. Determine: who, what, where, when, how, and why?

Conduct interviews individually at the incident scene and in a non-threatening environment. Ask open-ended questions such as "What did you observe?" and then do not interrupt respondents. To prompt responses, say, "Then what happened?" Wait until respondent has finished talking and only then ask clarifying questions to fill in information gaps. Always ask their opinion about corrective action.

Name of Injured Employee		Job Title		If other than HQ, Branch/Jobsite Location of Injury	
Task Performed when Injured		Date & Time Injury Occurred		Date and Time Reported to Supervisor	
Injured Employee's Department		Injured Employees Experience in Job Task (Check One) <input type="checkbox"/> New <input type="checkbox"/> Novice <input type="checkbox"/> Competent <input type="checkbox"/> Expert <input type="checkbox"/> Unauthorized		Was Task (Check One) <input type="checkbox"/> Routine <input type="checkbox"/> Infrequent <input type="checkbox"/> New Experience	
When Did Injury Occur in Shift (Check One) <input type="checkbox"/> Early <input type="checkbox"/> Mid <input type="checkbox"/> Near Break <input type="checkbox"/> Late, <input type="checkbox"/> Overtime		Occurred on Company Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Exact Location Where Injury Occurred	
When was On-Scene Observation of Incident Site made by Supervisor?		Photos/Sketches Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No		Any Witnesses? If "Yes," attach Statements <input type="checkbox"/> Yes <input type="checkbox"/> No	
Evidence Secured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was Post-Incident Drug Testing Administered? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Drug Test Performed, Where, Date, Time	
Who is the management person responsible for coordination of return to work and for maintaining regular contact with concern for injured worker?		Additional Comments:			
Have the injured worker and medical provider been informed that transitional work will be offered for immediate return to work within medical restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Nature of Injury and Body Parts Affected: (e.g., cut left thumb, broken right arm, strained lower back, etc.)					
Severity of Injury/Illness			Work Status Following Initial Medical Treatment		
<input type="checkbox"/> "Near-Miss" incident (no injury) <input type="checkbox"/> First-Aid (in house treatment only) <input type="checkbox"/> Minor Medical (initial doctor treatment, then release) <input type="checkbox"/> Serious (partial disability, continuing medical care) <input type="checkbox"/> Catastrophic (critical condition, severe disability, fatality)			<input type="checkbox"/> Full Duty Returned to work on next shift <input type="checkbox"/> Transitional Duty Returned to work on next shift <input type="checkbox"/> Lost Time (did not return to work on next shift)		
Mechanism of Injury:					
<input type="checkbox"/> Slip/Trip/Fall onto same level  <input type="checkbox"/> Fall from above level (ledge, platform, ladder, stairs) <input type="checkbox"/> Caught In/On/Between (pinched, snagged, grabbed)  <input type="checkbox"/> Overexertion (strain from force, exhaustion) <input type="checkbox"/> Respiratory Exposure		<input type="checkbox"/> Struck-Against (hit on, bumped into)  <input type="checkbox"/> Struck By (hit by something) <input type="checkbox"/> Repetitive Motion Condition  <input type="checkbox"/> Vehicle Incident		<input type="checkbox"/> Contact With (Electrical, Chemical, Heat/Cold, Blade) <input type="checkbox"/> Airborne Material in Eye <input type="checkbox"/> Bio-hazard Exposure (needle stick, blood) Other: _____	
Describe in Detail How the Incident Occurred					
Comment on equipment/tools, materials, people, vehicles, or environmental factors (such as noise, lighting, heat, cold etc.) that may have contributed.					

**Protective Gear Used by Injured Employee (when incident occurred)**

Comment on equipment/tools, materials, people, vehicles, or environmental factors (such as noise, lighting, heat, cold etc.) that may have contributed.

**Immediate Causes of Incident (identify both behavior(s) and condition(s). Check as many as applicable.**

- | Behaviors/Work Practices   | Physical Conditions  |
|--|--|
| <input type="checkbox"/> Using Improper Equipment (wrong type/damaged)<br><input type="checkbox"/> Abuse or Misuse of Equipment<br><input type="checkbox"/> Removing Safety Devices or making them inoperable<br><input type="checkbox"/> Failing to Use PPE or Seatbelts<br><input type="checkbox"/> Improper Placement/Arrangement (unstable)<br><input type="checkbox"/> Improper Handling Technique (help, grip, reach, posture)<br><input type="checkbox"/> Failure to Use Handling Equipment (carts, lifts, etc.)<br><input type="checkbox"/> Improper Body Position or Overreach (in harms way)<br><input type="checkbox"/> Working on Equipment in Motion<br><input type="checkbox"/> Performing at Unsafe Speed or Pace<br><input type="checkbox"/> Not Authorized or Qualified to Perform<br><input type="checkbox"/> Failure to Isolate/Secure/Lockout<br><input type="checkbox"/> Horseplay<br><input type="checkbox"/> Inadequate Ventilation | <input type="checkbox"/> Inadequate Guards/Barriers/Safety Devices<br><input type="checkbox"/> Inadequate or Improper Protective Equipment<br><input type="checkbox"/> Defective/Worn Tools or Equipment in Service<br><input type="checkbox"/> Congested/Restricted Area/No Separation<br><input type="checkbox"/> Fire or Explosion Hazard<br><input type="checkbox"/> Working Surface Unsafe (slippery, sloped)<br><input type="checkbox"/> Poor Housekeeping/Disorder/Traffic Flow<br><input type="checkbox"/> Noise/Vibration<br><input type="checkbox"/> Temperature Extremes<br><input type="checkbox"/> Visibility Inadequate (dark, glare, obscured)<br><input type="checkbox"/> Heavy Work Uncontrolled<br><input type="checkbox"/> Production Pace Unsafe<br><input type="checkbox"/> Emergency Systems/Provisions Inadequate |

Other/Comments:

**Root Causes of Incident (identify both personal factor(s) and management practice factor(s). Check as many as applicable.**

- | Possible Personal Factors   | Possible Management Practice Lacking  |
|---|---|
| <input type="checkbox"/> Knowledge Insufficient<br><input type="checkbox"/> Skill Insufficient<br><input type="checkbox"/> Experience Insufficient<br><input type="checkbox"/> Motivation Lacking<br><input type="checkbox"/> Fatigue (mental or physical)<br><input type="checkbox"/> Personal Issues<br><input type="checkbox"/> Other: | <input type="checkbox"/> Leadership/Supervision/Enforcement<br><input type="checkbox"/> Engineering/Design/Capacity/Containment<br><input type="checkbox"/> Process/Work Methods<br><input type="checkbox"/> Maintenance/Inspection program<br><input type="checkbox"/> Staffing/Manpower/Hiring Practices<br><input type="checkbox"/> Tools/Equipment Provided<br><input type="checkbox"/> Hazardous Materials Alternatives/Controls<br><input type="checkbox"/> Training/Development<br><input type="checkbox"/> Hazard Identification/Evaluation |

Other/Comments:

**Preventive Measures to be Considered. Check as many as applicable.**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> General Enforcement Improvement        | <input type="checkbox"/> Housekeeping/Disposal Improvement     | <input type="checkbox"/> Repair/Replace Equipment           | <input type="checkbox"/> P.P.E. Improvement         |
| <input type="checkbox"/> Training or Re-Training of Employees   | <input type="checkbox"/> Substitute Safer Alternative Material | <input type="checkbox"/> Congestion/Traffic Improvement     | <input type="checkbox"/> Work Method Improvement    |
| <input type="checkbox"/> Individual Corrective Counseling       | <input type="checkbox"/> Guards/Safety Devices Improved        | <input type="checkbox"/> Supply/Purchasing Improvement      | <input type="checkbox"/> Workstation Re-Design      |
| <input type="checkbox"/> Formal Procedure Development/ Revision | <input type="checkbox"/> Engineering/Process Improvements      | <input type="checkbox"/> Inspection/Maintenance Improvement | <input type="checkbox"/> Temperature Improvement    |
| <input type="checkbox"/> Staffing/Hiring Stds / Development     | <input type="checkbox"/> Visibility / Illumination Improved    | <input type="checkbox"/> Noise/Vibration Improvement        | <input type="checkbox"/> Ventilation Improvement    |
|   |  |   | <input type="checkbox"/> Discontinue/Eliminate Task |

<input type="checkbox"/> Rotation of Employees	<input type="checkbox"/> Storage / Arrangement Improvement	<input type="checkbox"/> Emergency Systems/Provisions	<input type="checkbox"/> Remove / Eliminate Hazard
<input type="checkbox"/> Employee Awareness/ Communication	<input type="checkbox"/> Provide Employee Incentive	<input type="checkbox"/> Safety Efforts Effectiveness	<input type="checkbox"/> Conduct Hazard Analysis
<input type="checkbox"/> Job Re-Assignment of Employee(s)	<input type="checkbox"/> Remove Employee Disincentive	<input type="checkbox"/> Warning System Provided	
<b>Other/Comments:</b>			
<b>Specific Corrective Action(s) Taken</b>	<b>Person(s) Responsible</b>	<b>Target Date</b>	<b>Date Completed</b>
<b>Report Completed by (Supervisor):</b>		<b>Date:</b>	
<b>Routed for Review to:</b>			
<b>Manager:</b>	<b>Executive:</b>	<b>Safety Committee:</b>	
<b>Comments:</b>	<b>Comments:</b>	<b>Comments:</b>	

**Incident Investigation Supplemental**

**Slip/Trip/Falls**

Type of Incident (circle): Slip Trip Fall

What did they slip on, trip over, or fall from (be specific)? \_\_\_\_\_

Describe general condition of floor \_\_\_\_\_

Yes No Restaurant quality slip resistant shoes worn? If not, what type? \_\_\_\_\_

Yes No Shoe soles contain excessive grime or clogged with food?

Yes No More than 1/3 of the rear heel tread is worn away?

Yes No Wet floor sign visible in area?

Yes No Are any lights out in the area?

Last time floor was mopped? \_\_\_\_\_ Last time floor was swept? \_\_\_\_\_

**Cuts**

Food item being prepared? \_\_\_\_\_

Yes No Did employee received knife skills instruction?

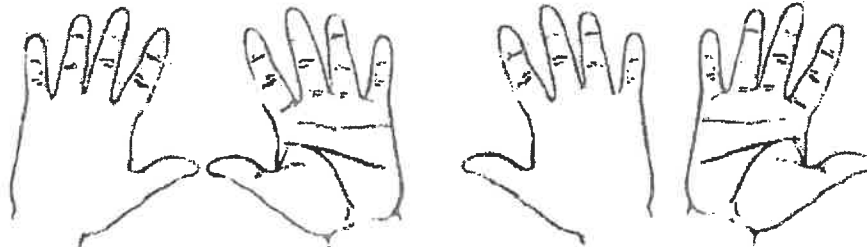
Type of knife? \_\_\_\_\_ Age of knife? \_\_\_\_\_

Last time knife was sharpened? \_\_\_\_\_

Yes No Wearing cut resistant glove? If no, location closest cut resistant glove? \_\_\_\_\_

Any distractions (talking co-worker, loud noise, etc.)? \_\_\_\_\_

Mark the location of the cut:



Left Back

Left Palm

Right Back

Right Palm

### Manual Material Handling Strains

Was the employee (circle) pushing pulling lifting object?

What object was being moved? \_\_\_\_\_ Weight of object? \_\_\_\_\_

Starting point of object? \_\_\_\_\_

Where was employee moving object to? \_\_\_\_\_

Yes No Was the employee reaching above shoulder height? If yes, where was the nearest step stool?

\_\_\_\_\_

Yes No Could a dolly be used to move object? If yes, where was the nearest dolly? \_\_\_\_\_

Yes No Was employee on a step stool or ladder at time of incident?

Yes No Did the employee bend over at the waist to move the item (vs. bend down with knees)?

How much lifting did the employee do prior to the injury (mark with an x on the sliding scale)?

←-----→  
Non-stop None

### Burns

What caused the burn (circle)? Grease Water Plate Food Beverage Equipment Steam

Activity when burn occurred? Carrying Object Removing Object Other: \_\_\_\_\_

Yes No Wearing oven mit(s)? If no, location of closest oven mit? \_\_\_\_\_

Yes No Using a rag/cloth as hand protection?

Yes No Did employee slip prior to burn? If yes, answer Slip/Trip/Fall questions.

Yes No If incident involved fryer, was food item dropped into the oil?

If incident involved steam, what was the source? \_\_\_\_\_

Yes No If incident involved steam, where was employee standing in relation to source of steam?