CITY OF JACKSON

Record of Training
On-The-Job Injury

Employee Name: _____ Employee #: _____

Dept. Name: _____ Supervisor/Dept. Head:_____

Employee Address:_____

Employee Phone# _____

I, _____, HAVE BEEN INFORMED BY THE CITY OF JACKSON OF THE ON-THE-JOB INJURY (OJI) POLICY AND THE CITY'S DEDICATION TO PROVIDE A SAFE & HEALTHY WORKPLACE.

IN THE EVENT OF AN INJURY/ILLNESS RESULTING FROM AND RELATED TO MY JOB WITH THE CITY OF JACKSON, I WILL ABIDE BY THE RULES OF THE ON-THE-JOB INJURY POLICY.

THE OJI ADMINISTRATOR AND/OR THE OJI THIRD PARTY ADMINISTRATOR IS AUTHORIZED TO RECEIVE ALL MEDICAL INFORMATION RELATED TO AN ON-THE-JOB INJURY BEFORE PAYMENT IS SUBMITTED. ALL MEDICAL INFORMATION PERTAINING TO AN ON-THE-JOB INJURY MAY BE SUBJECT TO REVIEW BY OFFICIALS OF THE CITY OF JACKSON, SPECIFICALLY MY SUPERVISOR/DEPARTMENT HEAD, RISK MANAGER, AND HUMAN RESOURCE DIRECTOR.

_____

SIGNATURE

_____

DATE