TO: **Bridgeway Directors and Supervisors**

FROM: **Lauralee Hatleli, Senior Director of Quality Management**

DATE: **08/24/2026**

RE: **Reporting Procedures for Bridgeway Workers' Compensation Claims and Work-Related Injuries and Illnesses**

Effective immediately, reporting procedures for work-related injuries are as follows:

1. All work-related injuries are to be reported to the employee's supervisor at the time of injury.
2. Company Nurse is to be contacted via phone immediately following the injury. Company Nurse's phone number is 1-833-980-5632. Company Nurse's information is provided on page 2 of this document and can also be found on the Bridgeway Employee Portal under the Employee Injury tab. If an injured employee is unable or refuses to contact Company Nurse, the employee's supervisor will call Company Nurse on their behalf. This generates a first report with NHRMA.
3. If the employee is seeking medical treatment beyond first aid, the Senior Director of Quality Management must be contacted. Appropriate contact information is listed below.
4. All Bridgeway work-related injury paperwork is to be completed within 24 hours of the injury. The injured employee will complete the first page of the Bridgeway Employee Safety Incident Report (SIR) found on page 3 of this document. The supervisor of the injured employee will complete the second page of the SIR found on page 4 of this document. Once completed, scan and email these forms to safety@bway.org. Include the Director and Vice President of the department in the email.
5. An Unusual Incident Report (UIR) should be submitted electronically as soon as possible, no later than 24 hours after the injury. The UIR can be found on the Bridgeway Employee Portal under the Unusual Incident tab. Always and only check "Employee Incident with or without injury" for the type of incident on the UIR.
6. Photographs should be taken of the injury (if available), damage caused to Bridgeway equipment, and the location of the incident and sent to safety@bway.org.
7. If treatment is declined, a Declination of Treatment form will be completed by the employee. Completed Declination of Treatment forms can be found on page 5 of this document and are to be scanned and emailed to safety@bway.org.
8. The last page of this document is specific to Kewanee only. The Senior Director of Quality Management must complete and sign the form. The injured employee must take the completed form with them for evaluation or testing.

NOTE: An injured on-duty employee may be subject to drug or alcohol testing. If an employee is in accident while driving either a Bridgeway vehicle or their personal vehicle for work purposes, they may be subject to drug or alcohol testing. If a Bridgeway vehicle is damaged, a police report must be filed. If the vehicle leaks fluids, the vehicle must be towed.

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IN CASE OF WORKPLACE INJURY

ACCION a seguir en caso de un accidente en el trabajo

COMPANY NURSE™
Because Accidents Happen™

AVAILABLE 24 HOURS A DAY

NHRMA MUTUAL

1-833-980-5632

1. **Injured worker notifies supervisor.**
   Empleado lesionado notifica a su supervisor.

2. **Supervisor/Injured worker immediately calls injury contact center.**
   Supervisor / Empleado lesionado llama de imediato al centro de contacto para lesiones.

3. **Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.**
   Company Nurse obtiene información por teléfono y asiste al empleado lesionado en adquirir el tratamiento médico adecuado.

NOTICE TO EMPLOYER/SUPERVISOR: Please post copies of this poster in multiple locations within your worksite. If the injury is non-life-threatening, please call Company Nurse prior to seeking treatment. Minor injuries should be reported prior to leaving the job site, when possible.

Bridgeway 7/29/26

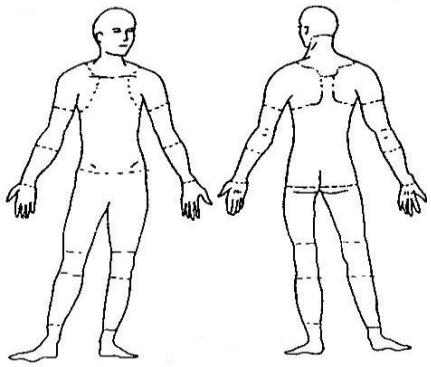
Bridgeway Employee
Safety Incident Report (SIR)

Instructions: The injured or ill Bridgeway employee will complete this form within 24 hours of an incident that results in serious injury or illness. Bridgeway employees will use this form to report all work-related employee injuries and illness. Complete all sections of this form leaving no blanks, then **scan and email the form to safety@bway.org** and include the department Director and Vice President in the email.

Step 1: Injured employee (to be completed by injured employee)

Injured/Ill Employee Name:	Today's Date:	Date of Incident:
Supervisor Name:	Phone Number:	Date of Birth:
Home Address:		
Department and Job Title:	Bridgeway ID #:	Bridgeway Location:

Part of body affected: (circle all that apply)



Nature of injury: (most serious)
- ☐ Abrasion, scrapes
- ☐ Amputation
- ☐ Broken bone
- ☐ Bruise
- ☐ Burn (heat)
- ☐ Burn (chemical)
- ☐ Concussion (to the head)
- ☐ Crushing Injury
- ☐ Cut, laceration, puncture
- ☐ Illness
- ☐ Sprain, strain
- ☐ Damage to a body system
- ☐ Other_____

This employee works:
- ☐ Regular full time
- ☐ Regular part time
- ☐ Seasonal
- ☐ Temporary

Months with this employer:

Months doing this job:

Step 2: Describe the incident (to be completed by injured employee)

Exact location of the incident:	Exact time and shift of incident:

What part of employee's workday? ☐ Entering or leaving work ☐ Doing normal work activities
☐ During meal period ☐ During break ☐ Working overtime ☐ Other_____

Names of witnesses (if any):	Has this body party been hurt before? If so, explain:

What personal protective equipment was being used (if any)?

Describe step-by-step the events that led to the injury. Include names of any machines, parts, objects, tools, materials and other important details.

Bridgeway Employee
Safety Incident Report (SIR)

Instructions: The supervisor of the injured or ill Bridgeway employee will complete this form within 24 hours of an incident that results in serious injury or illness. Include the injured or ill employee in the investigation if available. Complete all sections of this form leaving no blanks, then **scan and email the form to safety@bway.org** and include the department Director and Vice President in the email.

Step 3: Describe the incident (to be completed by supervisor)	
Name of Injured/Ill Employee:	Date of Injury/Illness:
Supervisor Name:	Date of Investigation:
Injured Employee Department:	Body Part (s) Injured:
Nature of Injury:	
Exact Location of the Incident:	Shift and Time the Incident Occurred:
Names of Witnesses (if any):	
What personal protective equipment was being used (if any)?	
What caused the event?	
Describe the events that led to the incident. Include names of machinery, parts, objects, tools, materials and all important details.	

Step 4: Why did the incident happen? (to be completed by supervisor)
Why did the unsafe conditions exist?
Why did the unsafe acts occur?
How can future incidents be prevented?

Step 5: Who completed and reviewed this form? (print)	
Written By:	Date:
Supervisor Signature:	Date:
Sr. Quality Director Signature:	Date:
Vice President Signature:	Date:

Declination of Treatment

It is our policy to provide prompt and appropriate medical treatment to employees for work-related injuries. There are situations that arise where notice of an injury may be made, and formal treatment is not necessary.

When an employee reports a work-related injury, the injury will be documented, and treatment will be offered. An employee may indicate a preference not to have formal medical treatment. If an employee declines medical treatment, we will have the employee sign this document indicating that they declined medical treatment. The company will continue to monitor the resolution of the complaints or injury until the time that the condition has been completely resolved. The employee will be asked to sign off that the condition has completely resolved.

If the condition is not improving readily during the monitoring period, or should the condition worsen, the employee will be sent for an evaluation to make sure the condition is properly addressed. There may be situations where an employee is sent for a medical clearance examination following their report of injury, even though the injured employee has declined medical treatment.

Date of Injury: _____

Injured Employee's Name: _____

Supervisor's Name: _____

Body Part(s) Injured: _____

☐ **I am declining medical treatment at this time. Should my condition worsen, or should I change my mind regarding treatment, I know I must inform my supervisor immediately.** Date: _____

Injured Employee's Signature: _____

Supervisor's Signature: _____

☐ **My injury/injuries have completely resolved.** Date: _____

Injured Employee's Signature: _____

Supervisor's Signature: _____

The following clinic locations may be utilized in the event of a Bridgeway employee work-related injury or illness requiring medical treatment beyond first aid. For on-site drug or alcohol screening questions, refer to Bridgeway's Reasonable Suspicion policy.

Galesburg/Monmouth
OSF Occupational Health Clinic
834 North Seminary Street
Suite 503
Galesburg, IL 61401
309-344-9411
7:30am – 5:00pm M-F

Macomb
Graham Medical Group Convenient Care Clinic
1630 East Jackson Street
Macomb, IL 61455
309-252-5191
7:00am – 7:00pm every day

Loves Park
OrthoIllinois
5875 East Riverside Blvd
Rockford, IL 61114
815-398-9491
8:00am – 8:00pm M-F
8:00am – 2:00pm Sa-Su

Pekin
OSF Occupational Health Clinic
719 North William Kumpf Blvd
Peoria, IL 61602
309-624-8525
6:30am – 5:00pm M-F

Kewanee
OSF St. Luke Medical Center Emergency Dept.
1051 West South Street
Kewanee, IL 61443
309-852-7500
*All drug screens report directly to St. Luke Laboratory (after 5pm, report to ED)
*All work-related injury evaluations report to the ED for evaluation
*The completed form on page 7 is required for Kewanee ONLY

Normal
OSF Occupational Health Clinic
1505 Eastland Drive
Bloomington, IL 61701
309-661-6270
8:00am – 5:00pm M-F

Midwest Truckers
(after business hours drug screening only)
217-525-0310 (main phone number) or
217-549-2216 for Macomb mobile collection or
309-714-2865 for all other mobile collections

OSF HEALTHCARE

(Patient must present Authorization and Photo ID at the time of service.)

Authorization for Examination or Treatment

Patient Name:_____ Social Security Number:_____

Employer:_____ Date of Birth:_____

Street Address:_____ Clinic Name: _____

Substance Abuse Testing(*check all that apply)
Type of test determined by Agility protocols if available

If company sends chain of custody with employee that will be used

☐ Non - DOT drug test ☐ Breath alcohol

☐ DOT drug test

Agency: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ USCG ☐ PHMSA

New Work Injury

☐ Injury ☐ Illness

Date of Injury _____

Type of Substance Abuse Testing

☐ Preplacement ☐ Reasonable cause

☐ Post-accident ☐ Random

☐ Follow-up

Special instructions/comments:

Work Injury Billing
NHRMA Mutual
Insurance Company
2302 Clearlake Blvd.
Champaign, IL 61822
Ph: 217-403-4900
Fx: 217-403-4901

Substance Testing Billing
Bridgeway
2323 Windish Dr
Attn: Lauralee Hatleli
Galesburg, IL 61401
309-344-2323

Authorized by:_____ Title:_____
Please print

Phone: _____ _____
Date