EMPLOYEE INCIDENT/ACCIDENT REPORT

* To Be Completed by Injured Employee *

Name: _____ Social Sec. No. _____

Home Address: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

City/State/Zip: _____ Telephone: ( ) _____

Title/Position: _____ Department: _____

Accident Location: _____

Date of Injury or onset of symptoms: _____ Time: _____ ☐ am ☐ pm

Described what caused the injury/symptoms, what you were doing just before the incident, and what you did after the incident (if you need more space, write on the back of this form). **Be specific-name any objects or substances involved:** _____

_____

_____

Were you performing regular duties at the time of accident? ☐ Yes ☐ No

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who? _____

Did you report this incident to anyone? ☐ Yes ☐ No If no, why not? _____

If yes, to whom did you report it?: _____ Title/Position: _____ When: _____

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger**):**

_____

_____

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull): _____

_____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe: _____

Provided by: _____

_____

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?: _____

Where?: _____ If treatment was not sought immediately, explain why?: _____

_____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury?: _____ By whom or where?: _____

Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury: _____

_____

Medical Release **- Under current Workers' Compensation Law, the employer is entitled to a signed medical release.** I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print): _____

Employee Signature: _____ **Date (required):** _____

EMPLOYEE INCIDENT / ACCIDENT REPORT

BACK INJURY REPORT

* To Be Completed When a Back Injury is Reported by the Injured Employee*

Name: _____ Social Sec. No. _____

Home Address: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

City/State/Zip: _____ Telephone: ( ) _____

Title/Position: _____ Department: _____

What part of your back hurts now? _____

When did you first notice this back pain? Date: _____ Time: _____ ☐ am ☐ pm

What were you doing at that time (explain in detail)? _____

_____

_____

If you were lifting an object, what was it and how heavy? _____

_____

_____

What did you feel? _____

What was the length of time between the injury and your disability, if any? _____

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who? _____

Did you report or mention this injury to anyone? ☐ Yes ☐ No If yes, who? _____ When? _____

Did you ever have a back injury before? ☐ Yes ☐ No If yes, when? _____

What part of your back? _____

Were you ever treated by a doctor? ☐ Yes ☐ No If so, when? _____

Has it given you further trouble since then? _____

Have you ever received or filed for compensation because of a back injury? ☐ Yes ☐ No

Any other injury? ☐ Yes ☐ No If yes, list Bureau of Workers' Compensation claim number(s): _____

_____

Medical Release **- Under current Workers' Compensation Law, the employer is entitled to a signed medical release.** I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print): _____

Employee Signature: _____ **Date (required):** _____

SUPERVISOR'S INVESTIGATION REPORT

Employee Name: _____ **Date of Injury:** _____

Was the employee killed as a result of the accident? If yes, indicate date of death:_____

Were there any witnesses to this injury? ☐ Yes ☐ No
If yes, witness statements should be attached.

Was the injury a result of horseplay, under the influence of drugs, or purposely self-inflicted? ☐ Yes ☐ No
If yes, please specify details on the back of this form or on another page.

Has there been any recent disciplinary action taken against this employee? ☐ Yes ☐ No
If so, please describe:

_____

_____

Has the employee submitted medical documentation for the injury? If so, please attach. ☐ Yes ☐ No

Was the employee treated in an emergency room or similar? ☐ Yes ☐ No

Was the employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

If known, please provide us with the name, address and telephone number of the attending physician:

_____

_____

_____

Has the employee returned to work? ☐ Yes ☐ No

Last Day worked _____ Returned to work _____

Does the employee have restrictions to duty? ☐ Yes ☐ No

Is the employee performing their full duties? ☐ Yes ☐ No

Have the conditions that caused the accident been controlled? ☐ Yes ☐ No

Describe action taken to prevent the accident in the future:_____

_____

_____

_____

_____

With the information you have, would you recommend the claim be accepted? ☐ Yes ☐ No

If no, why? _____

_____ _____

Supervisor Signature Date

_____ _____

Workers' Compensation Coordinator Signature Date

**Please attach completed incident reports, witness statements and any accumulated medical bills and information. Additional comments may be noted on the reverse side.

STATEMENT OF WITNESS TO ACCIDENT

I. INCIDENT INDENTIFICATION INFORMATION

Name of employee alleging incident: _____ Shift: _____

Title/Position: _____ Department: _____

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your Name: _____ Your Title/Position: _____

Your Address: _____ Your Phone Number: ( ) _____

_____

Did you see an accident involving the above employee: ☐ Yes ☐ No

If not, how did you learn about the accident? _____

_____

If you did see an accident occur?: Date of accident: _____

Time of accident: _____ ☐ am ☐ pm

Describe what you saw: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Your Signature Please Print Your Name Date

SUPERVISOR'S REPORT
OF RETURN TO WORK

To: Workers' Compensation Coordinator

From: _____
(Supervisor Name)

_____
(Department or Area)

The following employee has returned to work: _____.
(Employee's Name)

This employee returned to work on _____.
(Date)

This employee is (check all that apply):

☐ Performing their full duties with no restrictions.

☐ Performing their duties with restrictions.

☐ Has returned in a Transitional Work effort; and/or alternative duty has been assigned within restrictions.

☐ Is working their full schedule.

☐ Working a partial day for _____ hours per day during the time period from _____am/pm to _____am/pm.

Comments:_____
_____
_____

_____
Injured Worker Signature Date

_____
Supervisor/Department Head Signature Date

<u>FAX TO WORKERS' COMPENSATION COORDINATOR ASAP</u>

FORM D

RETURN TO WORK PLAN

To: _____
Injured Worker's Name

From: _____ _____
(Supervisor name) (Department or area)

You have been scheduled return to work on (date) _____ at the following time:_____.

You are working with the following restrictions as per your physician:

_____

_____

_____.

The following review and briefing has occurred:

- ☐ The physician's restrictions have been identified and clarified.
- ☐ The supervisor is able to understand the restrictions and provide accommodated work.
- ☐ A communication pathway to get support has been provided to the injured worker.
- ☐ A review of pertinent safety policies/practices has occurred.
- ☐ A review of pertinent human resources policies, including reporting off work, clocking in/out, and similar, have been reviewed.
- ☐ The Job Demand Analysis has been reviewed in conjunction with the restrictions indicated by the physician. Duties have been assigned as noted below.
- ☐ Requirements of the injured worker to work within restrictions have been clarified.
- ☐ Requirements of the supervisor to only assign work within restrictions have been clarified.
- ☐ Requirement of the injured worker to immediately go to their physician's office (or emergency room) if they are leaving work because they feel that they cannot perform the work or because they feel that they may have been re-injured.

Assigned Tasks (attach separate page if necessary):

Week	Assigned Duties	Evaluation/Review
Week 1		• Employee feedback • Supervisor review/feedback • Continued Modified Duty? ☐ • Full Return to Work? ☐
Week 2		• Employee feedback • Supervisor review • Continued Modified Duty? ☐ • Full Return to Work? ☐
Week 3		• Employee feedback • Supervisor review • Continued Modified Duty? ☐ • Full Return to Work? ☐

Week 4		• Employee feedback • Supervisor review • Continued Modified Duty? ☐ • Full Return to Work? ☐
Week 5		• Employee feedback • Supervisor review • Continued Modified Duty? ☐ • Full Return to Work? ☐
Week 6		• Employee feedback • Supervisor review • Continued Modified Duty? ☐ • Full Return to Work? ☐
Week 7		• Employee feedback • Supervisor review • Continued Modified Duty? ☐ • Full Return to Work? ☐
Week 8		• Employee feedback • Supervisor review • Continued Modified Duty? ☐ • Full Return to Work? ☐

Agreement:
I, the undersigned injured worker, agree to participate in the transitional work plan described herein. I agree to consider work to be performed carefully and to work within my restrictions, ask for help when work exceeds my abilities, to notify my supervisor if there are duties assigned that exceed my abilities, or if I need assistance.

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

cc: Workers' Compensation Coordinator
Supervisor file
Employee file

CLAIM TRACKING CHECKLIST

Demographic Information:

Injured Worker: _____	Title/Position: _____
Department: _____	Date of Injury: _____
Claim #: _____	Injury: _____

Tracking Items:

►ACCIDENT REPORTING FORMS:			
Employee Incident/Accident Report Completed:	☐ Yes	☐ No	Date: _____
Back Injury Incident/Accident Report Completed:	☐ Yes	☐ No	Date: _____
Supervisor's Investigation Report Completed:	☐ Yes	☐ No	Date: _____
Witness Statement Form Completed:	☐ Yes	☐ No	Date: _____
First Report of Injury (FROI) Form Received:	☐ Yes	☐ No	Date: _____
Managed Care Organization (MCO) Notified:	☐ Yes	☐ No	Date: _____
Third Party Administrator (TPA) Notified:	☐ Yes	☐ No	Date: _____
Claim Certified or Denied:	☐ Certified	☐ Denied	
Scheduled Return to Work Date:	Date: _____		
Actual Return to Work Date:	Date: _____		
Supervisor Report of Return to Work Received:	☐ Yes	☐ No	Date: _____
Return to Work Plan Developed and Received:	☐ Yes	☐ No	Date: _____
►Preliminary Outcome:			
Full Return to Work with No Restrictions:	☐ Yes	☐ No	Date: _____
Return to Work with Restrictions:	☐ Yes	☐ No	Date: _____
►Final Outcome:			
Full Return to Work:	☐ Yes	☐ No	Date: _____
Accommodated in Position:	☐ Yes	☐ No	Date: _____
New Position:	☐ Yes	☐ No	Date: _____
New Outside Job:	☐ Yes	☐ No	Date: _____
Medical Discharge:	☐ Yes	☐ No	Date: _____

Return To Work Tracking

Injured Worker Information	Date of Injury	Last Day Worked	Return to Work Date	Number of Lost Days
Employee: Supervisor:				
Employee: Supervisor:				
Employee: Supervisor:				
Employee: Supervisor:				
Employee: Supervisor:				
Employee: Supervisor:				
Employee: Supervisor:				
Employee: Supervisor:				
Employee: Supervisor:				
				Total Lost Days: