Mankato Area Public Schools

First Report of Injury Packet

Your Packet Includes: **Quick Reference Guide to Reporting Injuries**

1. **Employee's First Report of Injury**
2. **Supervisor's Report of Accident / Injury**
3. **SFM's Work Ability / Return-to-Work Form**

As of July 1, 2019, the ISD 77's Workers' Compensation Carrier is:

SFM
The Work Comp Experts

Quick Reference Guide - Reporting Work Injuries

When someone's injured at work……

If it's an emergency, call 911.

■ Otherwise, the employee and supervisor should call (855) 675-3501 together. (If no supervisor is available, the employee can call alone) Do this as soon as possible after you learn of an injury.

■ The registered nurse who answers will ask what happened and recommend what to do next, whether it's self-care, urgent care or even the emergency room.

■ The nurse will report the injury to SFM, your workers' compensation insurer. You don't need to fill out a first report of injury.

Contacts and Next Steps

When calling the hotline, the following information may be needed for identification purposes:

Employer: **Mankato Area Public Schools**
Location Name & Address: **Give your building information**
Policy Number: **1 1 7 8 2 5**
Your Organization's Contact – Claims Coordinator:
Scott Hogen, Director of Facilities & Safety

After the call…

■ If a doctor's visit is required, ask the employee to take along a report of work ability to be completed by the physician.

■ Gather additional information about the incident.

■ If recovery will require time off work, report this to SFM. Call 1-800-937-1181 to reach your claims representative.

■ Stay in contact with injured employees. Let them know they're missed, and you'll have jobs for them when they're ready to return to work.

■ Ask the injured worker to call their claims representative before undergoing diagnostic tests, such as MRIs or ordering medical equipment.

Contact SFM to report an injury:
855-675-3501 sfmic.com

General Questions:
952-838-4200 or 800-937-1181

MANKATO AREA PUBLIC SCHOOLS

EMPLOYEE'S FIRST REPORT OF INJURY

EMPLOYEE NAME	EMPLOYEE SOCIAL SECURITY NO	DATE OF INJURY
_____ LAST _____ FIRST _____ MIDDLE INI	_____ / ____ / _____	____ / ____ / ____

HOME ADDRESS (INCLUDE CITY & ZIP)	☐ MALE ☐ FEMALE / ☐ MARRIED ☐ SINGLE	WORK TIME: _____ AM _____ PM
OCCUPATION	**DATE OF BIRTH** _____ / _____ / _____	**HIRE DATE** _____ / ____ / _____
REGULAR DEPARTMENT	**DESIGNATED PHONE NUMBER**	**APPRENTICE** ☐ NO ☐ YES

WAGE INFORMATION AVERAGE WAGE / WEEK	RATE PER HOUR	DAYS PER WEEK	HOURS PER DAY

EMPLOYMENT STATUS: ☐ **FULL TIME** ☐ **PART TIME** ☐ **SEASONAL**

OCCURRENCE PLACE (Include Dept & Full Address)	DATE OF FIRST DAY OF LOST TIME _____ / _____ / _____	DATE EMPLOYER WAS NOTIFIED OF INJURY _____ / _____ / _____
	RETURN TO WORK DATE _____ / _____ / _____	DATE EMPLOYER WAS NOTIFIED OF LOST TIME _____ / _____ / _____
ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	DATE OF DEATH _____ / _____ / _____	TIME OF DAY INJURY OCCURRED _____ AM _____ PM

DESCRIBE HOW THE INJURY/ILLNESS OCCURRED, WHAT THE EMPLOYEE WAS DOING BEFORE THE INCIDENT (GIVE DETAILS) AND WHAT THE INJURY/ILLNESS WAS. (EXAMPLE: WORKER WAS DRIVING LIFT TRUCK WITH A PALLET OF BOXES WHEN THE TRUCK FLIPPED, PINNING WORKER'S FOOT).

WHAT WAS THE INJURY OR ILLNESS? (INCLUDE THE PARTS OF THE BODY INVOLVED. EXAMPLE: CHEMICAL BURN TO LEFT HAND, BROKEN LEFT LEG, PAIN IN LEFT WRIST)

WHAT TOOLS, EQUIPMENT, MACHINES, OBJECTS OR SUBSTANCES WERE INVOLVED? (EXAMPLE: CHLORINE, HAND SPRAYER, PALLET LIFT TRUCK, COMPUTER KEYBOARD)

1) WAS A STUDENT INVOLVED IN THIS INJURY? ☐ **YES** ☐ **NO** IF YES, COMPLETE AND ATTACH A COPY OF THE FILLED OUT PUPIL INJURY REPORT

2) WAS AN EXPOSURE INVOLVED? ☐ **YES** ☐ **NO** IF YES, COMPLETE THE EMPLOYEE EXPOSURE INFORMATION FORM WITH YOUR SITE NURSE

EXPOSURE INCIDENT: IS AN INDIVIDUAL'S BLOOD OR OTHER POTENTIALLY INFECTIOUS BODY FLUID CONTACTING ANOTHER PERSON'S MUCOUS MEMBRANE, NON-INTACT SKIN, OR A PUNCTURE INTO THE SKIN.

PHYSICIAN (NAME, TITLE, ADDRESS, PHONE) (*COMPLETE ONLY IF YOU SAW A DOCTOR FOR THIS INJURY*)	**HOSPITAL / CLINIC** (NAME & ADDRESS)
	WITNESS (NAME & PHONE NUMBER)
	DATE THIS FORM WAS COMPLETED _____ / _____ / _____

RETURN THIS FORM TO YOUR SUPERVISOR AND SEND OR FAX TO THE BUSINESS OFFICE WITHIN 24 HOURS
FAX: 387 4033 ATTENTION: DIRECTOR OF FACILITIES

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

UPDATED: 10/4/19

SUPERVISOR'S REPORT OF ACCIDENT / INJURY

(Please read and follow instructions on back)

Every accident should be investigated and the causes corrected so that more injuries and/or accidents will not occur. Do not overlook the so-called "unimportant" cases, because, except for "chance" they could also have been serious. It is only by thorough investigation that many of the real causes can be determined and corrected.

NAME OF EMPLOYEE:_____ SCHOOL:_____ DEPT:_____

DATE OF ACCIDENT:_____ TIME:_____ DID EMPLOYEE LOSE TIME FROM WORK? YES ☐ NO ☐

HOURS LOST ON DATE OF ACCIDENT:_____ HAS EMPLOYEE RETURNED TO WORK? YES ☐ NO ☐

JOB TITLE: _____ SERVICE WITH THE COMPANY: _____ YEARS IN PRESENT JOB: _____

GIVE US YOUR HONEST COMMENTS ON QUESTIONS BELOW. WE ARE NOT TRYING TO BLAME ANYONE. YOUR OPINION MAY HELP US PREVENT ACCIDENT REPETITION.

PLEASE ANSWER THE FOLLOWING:	CHECK "YES" OR "NO"	
1. Was injured person properly instructed in safe and efficient methods?.....	YES ☐	NO ☐
2. Did injured person violate any instructions?.....	YES ☐	NO ☐
3. Was necessary protective equipment worn? (if applicable).....	YES ☐	NO ☐
4. Did poor housekeeping contribute to injury?.....	YES ☐	NO ☐
5. Did horseplay cause the injury?.....	YES ☐	NO ☐
6. Was it caused by something which needed repairs?.....	YES ☐	NO ☐
7. Should a guard be provided?.....	YES ☐	NO ☐
8. Did any bodily defect contribute to injury?.....	YES ☐	NO ☐
9. Was it caused by an unsafe act?.....	YES ☐	NO ☐
10. Did injured report the injury to you, the supervisor, immediately?.....	YES ☐	NO ☐

ACCIDENT: *(Describe what injured person was doing at time of accident. What happened, who was involved, nature of injury, part of body affected)*

_____

_____

WITNESSES' NAMES: _____

UNSAFE ACTS: (*What did the employee or another person do incorrectly?)*

_____

_____

UNSAFE CONDITIONS: (*What unguarded or unsafe condition of machinery, equipment, building or premises was involved?*)

_____

_____

ACTIONS TAKEN: (*What did you do to correct the conditions which caused this injury?)*

_____

_____

REMEDIES: (*What should your organization do to prevent other injuries like this?)*

_____

_____

MEDICAL CARE: Did employee go to doctor or hospital? YES ☐ NO ☐

NAME of Doctor or Hospital: _____ Date of initial visit: _____

ADDRESS: _____ Phone Number: _____

AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION? YES☐ NO☐

REASONS WHY: _____

_____

REPORT SUBMITTED BY: _____ DATE: _____

Please return this form to the Director of Facilities at the Central Business Office

COMPLETION INSTRUCTIONS FOR SUPERVISORS' REPORT OF ACCIDENT (SRA)

The primary purpose of the SRA is to investigate the accident. It is also used to report the accident to the Central Office where the First Report of Injury is then completed by administrative personnel. The SRA should be filled out as soon as possible after the accident.

If the SRA is incomplete or delayed, corrective action may also be delayed. A delay in taking corrective action will probably result in the occurrence of a similar accident.

The initial information asked for at the top of the SRA concerning the injured person's name, age, job history, and loss of time from work is self-explanatory, but very necessary for eventual completion of the First Report of Injury.

The following is a line-by-line set of instructions for completing of the SRA by the Supervisor of the injured employee. Concrete examples of important parts of the form are given for your use. This report should **not** be completed by the injured person.

QUESTIONS

1. Was proper instruction given to the employee on how to do the job safely? Supervisors should instruct their employees on how to do the job efficiently and safely.

2. Referred to in question #1.

3. The supervisor should have told the employee what personal protective equipment is necessary to do the job. Did the employee wear the personal protective equipment when this job was being done?

4. Was the work area clean and well organized? (i.e., scraps on the floor, blocked aisles, wet floor, spilled food, etc.)

5. Was there inadequate supervision? Did horseplay or practical jokes contribute to the accident?

6. Was the injured person using equipment that was unsafe and in need of repair? (i.e., broken ladder, bad electric cord on drill, etc.)

7. Would a guard prevent another accident from happening? (i.e., guard around the belts and pulleys, railing properly in place, guard, on saw, etc.)

8. Did this person have any bodily defects which might have help cause the accident? (i.e., poor vision, previous back injury, etc.)

9. Most injuries are caused by unsafe acts. An Unsafe Act is something that the injured person or another person did, that he or she should not have done, which led to the accident. Below is a list of the most common unsafe acts and contributing factors:
   - a. Operating without authority
   - b. Failure to warn or secure
   - c. Operating at unsafe speed
   - d. Making safety devices inoperative
   - e. Using equipment, tools, materials or vehicles unsafely
   - f. Using defective equipment, materials, tools or vehicles
   - g. Failure to use personal protective equipment
   - h. Failure to use equipment provided (except personal protective equipment)
   - i. Unsafe loading, placing and mixing
   - j. Unsafe lifting, carrying (including insecure grip)
   - k. Taking an unsafe position
   - l. Adjusting, clearing jams, cleaning machinery in motion
   - m. Distracting, teasing
   - n. Poor housekeeping practices
   - o. Disregard of instructions
   - p. Lack of knowledge or skill
   - q. Act of other than injured
   - r. Other…

10. The accident should have been reported immediately to the supervisor, was it?

ACCIDENT:

1. Describe what the injured was doing at the time of the accident.
2. What happened?
3. Who was involved?
4. What injuries resulted?

(Example: John was drilling a hole in the ceiling and chips of plaster fell into his eye. (This answers questions 1 & 2.) John was wearing prescription safety glasses but got chips of plaster in his eye resulting in scratches to his eye (This answers questions 3 & 4). Note the names of witnesses, if any.

UNSAFE ACT: Refer to question 9 above and examples of Unsafe Acts. Example: John was not wearing proper personal protective equipment.

UNSAFE CONDITIONS:

- a. Defective tools, equipment, substances
- b. Unsafe design or construction
- c. Hazardous arrangement
- d. Improper illumination
- e. Improper ventilation
- f. Improper dress
- g. Poor housekeeping
- h. Congested area
- i. Other

REMEDY: Example – standard safety policy should be adopted that requires use of personal protective equipment. This policy should be strictly enforced by the supervisors.

MEDICAL CARE: Include all medical information that is known at this time. Do not delay the completion of this form for more complete information.

As supervisor, do you feel that this injury should be covered by workers' compensation benefits? As a general rule, if the employee is injured while at work, that injury is covered under workers' compensation. However, if you as supervisor have reason to suspect that the injury did not occur at work, please tell us. This is only an opinion and by itself will not deny benefits.

WORK ABILITY / RETURN-TO-WORK

SFM The Work Comp Experts®

Send itemized medical billings and records to:
SFM Companies, PO Box 9416, Mpls, MN 55440
Fax: (952) 838-2000 Phone: (800) 937-1181

Send this completed form with the employee

EMPLOYEE	HEIGHT	WEIGHT	DATE OF BIRTH

EMPLOYER	DATE OF INJURY/ILLNESS
Mankato Area Public Schools	

DIAGNOSIS	ICD-10 CODE

History, mechanism of injury, and findings:
Work related injury/illness? ☐ No ☐ Yes ☐ To be determined

Any pre-existing conditions affecting this injury/illness? ☐ No ☐ Yes, description:

Permanent partial disability? ☐ No ☐ Yes, _____%

Maximum Medical Improvement reached? ☐ No ☐ Yes, date reached _____

RETURN TO WORK

☐ Return to work ***with no limitations*** on mo:_____/ day:_____/ year:_____

☐ Return to work ***with limitations*** on mo:_____/ day:_____/ year:_____ through mo:_____/ day:_____/ year:_____

_____ has light-duty work available. Please call _____ at_____if you plan to take this employee off work.

☐ Unable to work from mo:_____/ day:_____/ year:_____ through mo:_____/ day:_____/ year:_____

EMPLOYEE'S CAPABILITIES

Body Part Affected: ☐ Upper Back ☐ Lower Back ☐ Shoulder ☐ Arm ☐ Elbow ☐ Wrist ☐ Leg ☐ Knee ☐ Ankle ☐ Foot

Side Affected: ☐ Left ☐ Right ☐ Both ☐ Neck ☐ Head ☐ Other Body Part Affected: _____

Lift / Carry	Not at All	Rare	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%
0-9 lbs	☐	☐	☐	☐	☐
10-19 lbs	☐	☐	☐	☐	☐
20-29-lbs	☐	☐	☐	☐	☐
30-39 lbs	☐	☐	☐	☐	☐
40-49 lbs	☐	☐	☐	☐	☐
No lift from floor	☐	☐	☐	☐	☐

Push / Pull without resistance					
0-19 lbs	☐	☐	☐	☐	☐
20-40 lbs	☐	☐	☐	☐	☐
> 40 lbs	☐	☐	☐	☐	☐
Bend	☐	☐	☐	☐	☐
Twist / turn	☐	☐	☐	☐	☐
Kneel / squat	☐	☐	☐	☐	☐
Sit	☐	☐	☐	☐	☐
Stand / walk	☐	☐	☐	☐	☐
Ladder/stair climb	☐	☐	☐	☐	☐

Hand, wrist, shoulder activities					
Avoid prolonged, repetitive or forceful:	**Not at All**	**Rare**	**Occasional 0-33%**	**Frequent 34-66%**	**Continuous 67-100%**
Gripping/grasping	☐	☐	☐	☐	☐
Repetitive wrist motion	☐	☐	☐	☐	☐
Reaching:	☐	☐	☐	☐	☐
Above shoulder	☐	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐	☐
Below shoulder	☐	☐	☐	☐	☐

Restrictions: circle:

Keyboard hrs/shift	0	1-2	3-4	5-6	7
Writing hrs/shift	0	1-2	3-4	5-6	7

Total spread out evenly over shift at _____intervals

Change positions every:
As needed ☐ Worksite stretches ☐
Half hour ☐ Exercises ☐
One hour ☐ (per handout)
Two hours ☐ Other: _____

Comments:

INSTRUCTIONS

☐ Keep wound clean and dry. Change dressing every_____

☐ Medication:_____

☐ Ice _____ min._____ ☐ Heat _____ min._____ ☐ Splint / brace _____

☐ Referral_____ **Follow-up appointment scheduled for:** _____

THIS TREATMENT HAS BEEN DISCUSSED WITH THE EMPLOYEE

Clinic:	Clinic Address:	License / Regis#:	Date of Exam:
Health Care Provider Name (printed):	**Health Care Provider's Signature:**	**Phone:**	**Fax:**