WORKERS COMPENSATION
CLAIM REPORTING PROCEDURES

This Claim Kit includes the following documents:

- Work Accident Reporting Protocol
- Supervisor Checklist for Employee Injury
- WC Supervisor Report (required)
  The employee's **Supervisor** must complete this form.
- Employer's Authorization Form for Woodlake Occupational Health (required)
  The employee's **Supervisor** must complete this form.
- Woodlake Occupational Health map including address and office hours
- Injured Worker Responsibilities Instructions
- WC Employee Injury Report (required)
  The **injured Employee** must complete this form. A description of the incident should be included on the back of this form. Employee must be very specific as to what exact body part was injured.
- Authorization for Release of Health Information form (required)
  This form must be completed and signed by the **injured Employee**. If the employee refuses to sign it, the supervisor should note that on the form and return it with the rest of the paperwork. The kit is incomplete if this page is not returned.
- WC Witness Report (required if someone was present)
  This form must be completed and signed by each **witness** that was present at the time of the accident.

Work Accident Reporting Protocol

Every effort should be made to prevent work place injuries to employees. In the event of an employee work related injury, the following procedures should be followed.

After an employee injury:

1. It is the policy of this organization that all employee related workplace injuries be reported immediately and no later than **24 hours** after the incident to their direct supervisor or person in charge of the facility.

2. At the time of the incident, the supervisor will be responsible for having the employee complete the employee incident report, Injured Worker's Responsibility form and Authorization For Release of Health Information form. The forms must be completed immediately unless the injury requires emergency medical attention.

3. The supervisor will also have any and all witnesses fully complete the WC Witness Report.

4. The supervisor will also fully complete the Supervisor's Report on their own, without the employee, based on what was reported to him/her.

5. All reports are to be submitted to Tina Cruz who will forward it on to the Workers' Compensation Claims Administrator. Please call Tina as soon as possible so that the accident can be evaluated for compensability.

6. For minor injuries, FIRST AID can and should be administered by the organization.

7. If further medical attention is warranted the employee will be directed to the organization's designated medical provider. The employee has a right to refuse and go to his/her own physician if he/she chooses.

OUR WORKERS' COMPENSATION MEDICAL PROVIDER IS:

Woodlake Occupational Health
1111 Superior St., Suite 506
Melrose Park, IL 60160
Phone 708-919-9900
Fax 708-919-9901

8. If it is an Emergency situation the employee will be transported to the nearest emergency medical facility for immediate care.

Supervisor Checklist for Employee Injury

1. If injured employee requires emergency medical attention, please attend to the staff member as appropriate.

2. Upon notification of employee injury have the employee explain incident location, who was present, specific body parts injured, why it occurred, what safety precautions were used or not used. Complete the Supervisor Report in detail.

3. Have employee fill out Employee Injury Report in detail. The form must be completed with all blanks filled in.

4. Perform accident investigation by taking employee to the scene of incident. Have employee explain incident step by step. Ask detailed questions regarding incident. Determine if there was a witness. Was the employee working within their job description? Were safety precautions used (work area clean & hazard free, wearing proper footwear, etc.).

5. Determine if any other medical attention is warranted.

6. If medical attention is warranted, send the injured employee to Woodlake Occupational Health, 1111 Superior St., Suite #506, Melrose Park, IL 60160, or his/her own physician. If sending to Woodlake, complete the enclosed Employer's Authorization Form for Woodlake Occupational Health form and have the employee bring it with them to the facility.

7. Phone or email Tina Cruz immediately at (708) 863-4856 or tcruz@cicd99.edu to notify her of the injury. Let her know if employee is requiring medical treatment.

8. Instruct employee to **contact Tina Cruz** after medical attention is completed. The employee should provide all forms from the medical facility including restricted or modified Return to Work Note, prescriptions & time & date of follow up appointments.

9. Send completed WC Supervisor Report, Employee Injury Report, Injured Workers Responsibilities form and Authorization for Release of Health Information form via email to Tina Cruz at TCruz@cicd99.edu, then send hard copy of the report via inter-school mail to Tina Cruz at the administration building.

10. The employee must submit a release specifying that he/she may work "at full duty" or "without restrictions" before being allowed to return to work if medical treatment had been sought. <u>The employee should not be allowed to work if the release was not submitted to you or Tina Cruz prior to starting their workday.</u>

Injured Workers Responsibilities

1. Employee must notify supervisor immediately, (no exceptions). Failure to report an injury immediately can hinder the claim.

2. Employee must fill out the **Employee Injury Report, Authorization for Release of Health Information form and Injured Workers Responsibilities form**. Immediate supervisors will have the employee complete the forms at the time the reported injury. No employee should leave the facility (unless it is a medical emergency) without completing these forms and returning them to their immediate supervisor.

3. Injured Employees must follow up with their supervisor immediately after evaluation/treatment and forward all medical status information related to their injury. Injured employees must make immediate contact with their supervisor or Tina Cruz in the event restricted duty or 'off' work situations that have been established by the evaluating physician.

4. Upon receipt of a physicians work restriction, the injured employee will bring a copy of the restrictions to the supervisor for review.

5. All medical appointments will meet in accordance with the facility policy and must be approved by the facility administrator or supervisor.

6. In order to return to work after an injury that requires medical treatment other than first aid, we will require a descriptive release from your physician stating that you may return to work "at full duty" or "without restrictions".

7. Please remember that there is no guarantee that a claim will be accepted; however, a report must be completed for any injury occurring at the workplace and all injuries will be investigated. Although a report must be completed for all injuries, please remember that you are responsible for all of your actions at the workplace and are expected to apply safe work practices.

_____

Employee

_____ _____

Supervisor Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Participant Name:	Social Security Number:	Birth Date:

Enter name of any physicians treating you for the injury.

I hereby authorize Cicero School District #99; _____;_____ (my health care provider(s)) to release and disclose the medical information and other records listed below that may include Protected Health Information about me to IPMG Employee Benefits Services (IPMG), at 225 Smith Road, St. Charles, IL 60174. "Protected Health Information" or "PHI" includes any information that relates to (1) My past, present or future physical or mental health or condition; or (2) Health care I have received or will receive; or (3) Payment for health care I have received or will receive.

Purpose of Disclosure. All such medical and PHI may be disclosed to IPMG and/or individuals working on its behalf for purpose of informing them of my medical condition and treatment, as reasonably requested for workers' compensation purposes, certification and payment of medical expenses, and discharge planning, ongoing case management, wellness service coordination, and other integrated care management services as disclosed to me by IPMG at the time of this Authorization.

The checked boxes will only allow us to obtain information on the current injury.

The following specific information to be disclosed:

[ ] All medical and billing records or any other information maintained by you (including records prepared by others that are in your possession) regarding the above listed Participant;

or only the following:

- [☑] Health Treatment [ ] Dental Treatment [ ] Vision Treatment
- [ ] Other _____
- [☑] Records related to the following treatment: This injury only
- [ ] Related to the following time period(s): _____ to _____

Initial if you understand the statements.

I understand that the records to be disclosed pursuant to this Authorization may contain records or information relating to treatment or participation in the following: *Initials*

- Federally assisted drug or alcohol abuse programs _____
- HIV Testing or HIV or AIDS Status _____
- Diagnosis and Treatment of Mental or Psychological Health _____
- Genetic testing information and/or records _____

I understand that such information is subject to special protections pursuant to state and federal laws. By my initials, I authorize the use or disclosure of such records if they are otherwise included within the scope of this Authorization

I understand that IPMG shall be authorized to use and disclose my PHI in the manner provided under applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), as described in its *Notice of Privacy Rights*. I have the right to revoke this Authorization in writing, except to the extent the provider has taken action in reliance upon this Authorization. I also understand a photocopy or facsimile of this Authorization shall be considered as effective and valid as the original. I understand that I may see and copy the information described on this form if I ask for it, and that I may obtain a copy of this form after I sign it. *I understand that this Authorization is voluntary and that I may refuse to sign this Authorization*. My refusal to sign will not affect my ability to seek and receive treatment, payment for submitted claims or maintain other eligibility for any other coverage provided under my employer's employee benefit plan(s).

I understand that my Protected Health Information may also be used or disclosed for purposes of responding to the lawsuit or claim brought by me or involving me. I understand that my PHI may by made available to various parties also involved with or defending such legal action by me or involving me, and that the information, once disclosed, might no longer be subject to certain state or federal privacy protections once released.

Enter the date if you choose to do so.

This Authorization expires on the earlier of _____, 201__ or the following event: at the time my Worker's Compensation claim is officially closed, but such expiration will not be effective as to records already released in reliance on the Authorization.

Sign and date here.

_____ _____

Signature of Participant or Personal Representative Date

Personal Representative Section

If a Personal Representative executes this form, that Personal Representative warrants that he or she has authority to sign this form on the basis of:

- ☐ Legal Authority (Power of Attorney, etc.) Please attach documentary evidence.
- ☐ Parent, Guardian or other individual acting *in loco parentis*
- ☐ Written Designation by the Patient or Participant

Woodlake
OCCUPATIONAL HEALTH

EMPLOYER'S AUTHORIZATION FORM FOR WOODLAKE OCCUPATIONAL HEALTH

Name: _____ **DOB:** _____
LAST FIRST MM/DD/YYYY

Date of Injury: _____ **Date of Authorization:** _____

Company Name: _____ **Company Location:** _____

Authorizes By: _____ **Title:** _____

Phone #: _____

☐ **Work-related Injury**

After hours, proceed directly to your nearest emergency department.

Evaluations

Job Title: _____

- ☐ Physical Exam
- ☐ Audiogram
- ☐ Lift Assessment
- ☐ Return to Work Physical
- ☐ Respirator Clearance
- ☐ Respirator Fit Test
- ☐ Hazmat
- ☐ Asbestos

DOT Physical

- ☐ Pre-Placement
- ☐ Recertification

Substance Abuse Testing

- ☐ Rapid Drug Screen
- ☐ Non-Regulated 5 Panel Drug Screen
- ☐ Non-Regulated 10 Panel Screen
- ☐ DOT Regulated Drug Screen
- ☐ Hair Collection Drug Test
- ☐ Breath Alcohol Test

Reason for Testing

- ☐ Pre-Placement
- ☐ Random
- ☐ Reasonable Suspicion
- ☐ Post-Accident
- ☐ Follow Up

Immunizations / Titers

- ☐ Hepatitis B
- ☐ TDAP
- ☐ _____
- ☐ _____
- ☐ _____

Other

_____

Patient MUST present photo ID at time of service.

Woodlake

OCCUPATIONAL HEALTH

Woodlake Occupational Health
1111 Superior St. - Suite #506
Melrose Park, IL 60160
Phone: 708-919-9900 I Fax 708-919-9901
occupational.health@woodlakespecialty.com

Hours of Operation: Monday–Friday 7AM-7PM

ICRMT
WC Supervisor Report
(to be completed by supervisor of injured employee)

Injured Employee Name: _____ SSN: _____

Employee Home Phone: _____ Employee's approximate weekly wage: _____

Supervisor's Name and Title: _____

Date/Time of Accident: _____ Date/Time Employee Reported: _____

Medical Expenses so far (if known): _____

Did/will employee lose time from work as a result of this accident? ☐ Yes ☐ No

If yes, please list dates/timeframes missed due to this accident:_____
If lost time: Did or will the lost time exceed 3 consecutive scheduled work shifts? ☐ Yes ☐ No
Is there a possibility of accommodating a modified duty position during any recovery period? ☐ Yes ☐ No

If no, reason why: _____

Was medical treatment performed outside of the employer's facility? ☐ Yes ☐ No

If yes, was this medical provider (select all that apply): ☐ Occupational Health Provider
☐ Chosen by employee
☐ Other

Did the employee see more than one physician for this accident? ☐ Yes ☐ No

What object or substance, if any, directly harmed the employee? _____

_____

Did the accident occur on the employer's premises? ☐ Yes ☐ No

Please review the employee's report of injury. Do you agree with the employee's details of this accident? ☐ Yes ☐ No

If no, please explain thoroughly (use 2nd sheet if necessary): _____

_____

_____

What did the employee tell you regarding what happened for the incident to occur? _____

_____

_____

What was the sequence of events that led up to the accident? What material, equipment and tools were involved?_____

_____

What were the environmental conditions at the accident site? _____

_____

_____

What was done immediately after the accident? _____

_____

_____

Specify body parts injured in this accident: _____

Injury Type (i.e. sprain, fracture, etc.): _____

Accident Location: _____

Loss Causation: _____

What conditions or actions contributed to the accident? _____

_____

_____

What system design and implementation problems contributed to the accident occurrence? _____

_____

What actions will be taken to reduce unsafe conditions and actions? _____

_____

What actions will be taken to strengthen system design and implementation? _____

_____

_____

Would you like Method Management to contact you for further risk management assistance? ☐ Yes ☐ No

Do you believe an outside/3rd party is responsible for this accident occurring? ☐ Yes ☐ No

If yes, please indicate the responsible party's name, address and phone number if known: _____

_____

I agree the above is true and accurate

Supervisor Name: _____ Supervisor Phone: _____

Supervisor's Signature:_____ Date: _____

ICRMT
WC Employee Injury Report
(to be completed by injured employee)

Your Name: _____Home Phone: _____

Hire Date:_____ SSN: _____ Date of Birth: _____

Home Address & Phone:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced # Dependents: _____

Date/Time of Incident: _____ Time Shift Began: _____ Date/Time Reported: _____

Address of accident occurrence: _____

Body part and how it was affected: _____

_____

What were you doing when the accident occurred? _____

Reason for being in the area: _____

_____

How did the accident occur ? (use 2nd sheet if necessary): _____

_____

_____

Who else saw the incident? _____

To whom did you report the incident? _____

Have you received first aid? ☐ Yes ☐ No Were you treated in the Emergency Room? ☐ Yes ☐ No
If yes, check One: ☐ On Premise Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No
☐ Outside medical assistance Has your doctor taken you off of work? ☐ Yes ☐ No
☐ Both
When is your next medical appointment? _____

Name, address, phone and fax # (if available) of medical facility where treatment was sought: _____

_____

Date/Time of such treatment: _____

Prior Workers' Compensation Claims? ☐ Yes ☐ No

If yes, please explain using 2nd sheet if necessary (i.e. date, body part, injury specifics): _____

_____

_____

I agree the above is true and accurate

Employee's Signature: _____ Date: _____

ICRMT
WC Witness Report
(to be completed by accident witness)

Injured Employee Name: _____

Your Name: _____ Your Phone Number: _____

Your Address: _____

Your relationship with injured employee (check one): ☐ Co-worker ☐ Other

Date/Time of Incident: _____ Today's Date/Time: _____

What was the employee doing at the time of the accident? _____

_____

What was the sequence of events that led up to the accident? _____

_____

_____

What was done immediately after the incident? _____

_____

_____

What were the environmental conditions at the accident site? _____

_____

What materials, equipment and tools were involved? _____

_____

I agree the above is true and accurate

Witness Name (please print): _____

Witness' Signature:_____ Date: _____