Injury Management Packet

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Injury Reporting Guide

Reporting Process

All work-related accidents, injuries and near misses are to be reported immediately. Please follow the reporting guidelines below:

• Employee must report injury to supervisor immediately.
• Supervisor informs Human Resources & Safety immediately.
• Supervisor submits accident investigations to Human Resources by the end of the shift.
• All claims must be submitted to United Heartland within 1 business day.
• All workers have the right to report a work-related injury or illness, without being retaliated against.

In the case of a catastrophic or fatality claim, please contact United Heartland immediately at (800) 258-2667.

OSHA requires employers to report any worker fatality within 8 hours, and any amputation, loss of an eye or hospitalization of a worker within 24 hours at (800) 321-6742.

Resources and Responsibilities

Employee

The documents in this packet that are meant for employee use are labeled with a red box with an “E” in the upper right corner.

• Fill out Employee Report of Injury (p. 3)
• Sign the “Medical Communications Authorization” (p. 9) and give to supervisor.
• Take the following forms to medical provider:
  o Medical Provider Return To Work (RTW) Letter (p. 5)
  o Work Status Report/Medical Service Form (p. 6)
  o Prescription First Fill Form (p. 7 and 8)
  o Must provide completed Work Status Report/Medical Services Form to HR after every appointment, before you return to work.

Supervisor

The documents in this packet that are meant for supervisor use are labeled with a tan box with an “S” in the upper right corner.

• Ensure proper medical attention is sought. Refer to occupational health clinic unless it is an emergency.
• Have the employee sign the “Medical Communications Authorization” (p. 9).
• Send completed Employee Report of Injury to HR immediately.
• Complete Supervisor Accident Investigation (p. 10) within 24 hrs.
• Send completed Supervisor Investigation and Witness Statements (p. 10 and 11) to HR within 5 days.
• Review and accommodate modified duty instructions from Work Status Report. HR will assist with modified duty placement as needed.
• Once modified duty has been identified, fill out Modified Duty Work Agreement with the employee (p. 12)
• Each week fill out the Modified Duty Work Schedule with the employee (p. 13).
• Follow-up with employee until released to regular work.
Employee Report of Injury

Name: ___________________________________ Address: ___________________________________

Phone #: ___________________ Birth Date: ___________ Date of Hire: ______________

Accident Occur on Premises: [ ] Yes [ ] No  Detailed Location: _________________________

Date of Injury: ______________ Time: ___________ [ ] am [ ] pm  Shift: ___________

Date Reported: ______________ Witnesses: ___________________________________________

What were you doing just before incident occurred: ______________________________________

Describe the accident in detail/what happened: _________________________________________

What object or substance directly harmed the employee: ________________________________

<table>
<thead>
<tr>
<th>Injured Area</th>
<th>Indicate Area of Injury</th>
<th>Type of Injury</th>
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</thead>
<tbody>
<tr>
<td>1 Head</td>
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<td>1 Abrasion</td>
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<td>2 Eye:</td>
<td>L/R</td>
<td>2 Amputation</td>
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<td>3 Shoulder</td>
<td>L/R</td>
<td>3 Bite:</td>
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<td>4 Arm</td>
<td>L/R</td>
<td>4 Bruise</td>
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<td>5 Elbow</td>
<td>L/R</td>
<td>5 Burn</td>
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<td>6 Wrist</td>
<td>L/R</td>
<td>6 Concussion</td>
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<td>7 Hand</td>
<td>L/R</td>
<td>7 Cut/Laceration</td>
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<td>8 Finger:</td>
<td>Specify</td>
<td>8 Foreign Body</td>
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<td>9 Fracture</td>
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<td>10 Hearing Impaired</td>
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<td>11 Infection</td>
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<td>12 Pain:</td>
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<td>13 Puncture</td>
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<td>16 Strain/Sprain</td>
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<td>11 Abdomen</td>
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<td>12 Pelvis</td>
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<td>13 Hip</td>
<td>L/R</td>
<td>___________</td>
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<td>14 Leg</td>
<td>L/R</td>
<td>___________</td>
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<td>15 Knee</td>
<td>L/R</td>
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<td>16 Ankle</td>
<td>L/R</td>
<td>___________</td>
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<tr>
<td>17 Foot</td>
<td>L/R</td>
<td>___________</td>
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<tr>
<td>18 Toe:</td>
<td>Specify</td>
<td>___________</td>
</tr>
</tbody>
</table>

Employee’s suggested action to prevent recurrence: ________________________________

Employee Signature: ___________________________ Date: ____________________________

IMMEDIATE ACTIONS: Prior to resuming work following incident:

Any unsafe conditions with equipment or process that caused accident: [ ] Yes [ ] No  Supervisor Signature ___________________________

If yes, list condition and corrective actions to eliminate the conditions: ________________________________

THIS PAGE MUST BE COMPLETED AND SUBMITTED PRIOR TO LEAVING YOUR SHIFT

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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. In the event that 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.

In the event that a 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.  

Injured Employee’s Signature: ____________________________

Supervisor’s Signature: ____________________________

☐ My injury/injuries have completely resolved.

Injured Employee’s Signature: ____________________________

Supervisor’s Signature: ____________________________
Medical Provider Return to Work Letter

Subject: Modified Duty Program

Dear Health Care Provider:

Enter Company Name believes that the prevention of occupational injuries and illnesses cannot be overemphasized. The protection of our number one resource, our employees, is of paramount importance.

However, in the event of an occupational injury or illness, Enter Company Name believes that it is our responsibility to accommodate an employee by maintaining a Modified Duty Program. This program is designed to provide meaningful work activities for an employee during the time that they are rehabilitating, until they are able to return to their normal work assignment.

In order for this program to continue its success, a coordinated effort between the employee, their health care provider, Enter Company Name and our agents is imperative.

Please complete and return the attached Medical Representative’s Return to Work Recommendations Form. Using your evaluation of the employee’s ability to work, we are able to determine what modified duty work assignments are available.

Enter Company Name appreciates your cooperation. If you have any questions, please contact (designated person or department and phone).

_______________________________________
(Signed by Company Representative)

Name and Title of Company Representative
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WORK STATUS REPORT/MEDICAL SERVICE FORM

EMPLOYEE INFORMATION:

Name: 
Date of Birth: / / 
Social Security Number: / / 
Phone #: ( ) - ext.
Date of Injury: / / 
Time of Injury: a.m. p.m.
Job Description:
Employee to Receive Medical Attention at: Clinic Hospital Physician:

EMPLOYER INFORMATION:

Company: 
Phone #: ( ) - ext. 
Date Notified: / / 
Authorized Employer Signature: Date: / / 

EMPLOYER HAS LIGHT DUTY WORK AVAILABLE

TO BE COMPLETED BY PROVIDER:

Diagnosis: 

Date of Examination: / / 
Time: a.m. p.m.
Treatment Plan: Must return for re-evaluation on: / /
To receive PT/OT services Duration: x week for weeks
Surgery Scheduled: / / 
Time: a.m. p.m.
Inpatient Outpatient
No further care required. Discharge Date: / / 

Expected Healing Time: 
Days Weeks Months

Other:

Current Status: 
May work full duty now (no restrictions) / / (Date)
May work light duty now with identified restrictions through / /
Presently working as of: / /
May not work until / / 
Full Duty Light Duty

Degree of bend: 

No sitting No standing No walking

Sitting job only No climbing or overhead work

May not use: Right hand Left hand

Keep dressing/wound clean and dry

Medication may cause drowsiness. Use caution operating machinery or equipment.

Comments:

NOTE: If inpatient admission is scheduled, notify United Heartland immediately at: 1-800-258-2667

PROVIDER INFORMATION:

Physician Name: 
Phone #: ( ) - ext.
Physician Signature: 
Date: / / 

Employee: To expedite prompt claim handling, this complete form is to be returned to your employer either on the same day of the appointment or, should lost time be incurred, it is to be forwarded to your employer the day following the appointment.
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Medical Communications Authorization

I unconditionally authorize all medical doctors, licensed physicians, medical practitioners, surgeons, doctors of osteopathy, chiropractors, any medical-related facilities, insurance companies, other organizations, corporations, institutions, or persons that have any records, knowledge or information, including my mental or physical health, history, condition or welfare, to supply all such information to my employer and its insurers, including United Heartland, Accident Fund Insurance Company of America, their third-party claims administrators, attorneys, consultants, nurses and vendors which may participate in the evaluation and recruitment of information to determine my entitlement to benefits under any workers' compensation or occupational disease acts, or in the coordination of medical or vocational rehabilitation. This authorization includes, but is not limited to, the furnishing and delivery of reproduced or photographic copies of notes, reports, records, intake form and films.

I expressly authorize any treating physician or other medical care provider to communicate orally or in writing with the above-described entities regarding my past, present and future care and treatment, and to any other issues including but not limited to my diagnosis, prognosis, the causal connection of any injury or condition of ill being to my employment, treatment plan, nature and extent of injury, and my ability to work. I hereby waive any doctor-patient privilege resulting from any consultation, examination or treatment with or by you, and any relevant regulations under the Health Insurance Portability & Accountability Act. In addition, any treating physician or medical provider is authorized to review and discuss any additional records, films or information provided to them.

I understand that the persons, organizations or above-referenced entities that I am authorizing to share and communicate my information to may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits based on my decision to sign this authorization. I know that federal law may not protect my information once it is disclosed, and that my information may be shared with someone else after it is disclosed. I understand I have the right to rescind this authorization at any time, and that revocation of this authorization must be made in writing. I know that any communications or actions made prior to the revocation of this authorization will not be impacted by a revocation.

A photocopy of this authorization shall be as valid as the original. This release will remain valid for the duration of my workers’ compensation or occupational disease claim, unless expressly rescinded in writing. I understand that after signing this authorization, I will be provided with a copy of it.

I have read and understand the information contained in this medical and communications release.

Social Security Number: ____________________________ Date of Birth: ____________________________

Signature: ____________________________ Date: ____________________________

Print Name: ____________________________

Address: ____________________________

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
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Supervisor Accident Investigation

Employee Name: ___________________________ Phone #: ___________________________

Accident Occur on Premises: □ Yes □ No Detailed Location: ___________________________

Date of Injury: ___________________________ Time: ___________________________ □ am □ pm Shift: ___________________________

Date Reported: ___________________________ Witnesses: ___________________________

Describe the accident in detail/what happened: __________________________________________

What object or substance directly harmed the employee: ___________________________

Immediate Care: □ None □ First Aid □ Medical Clinic □ Emergency Room □ Medical Provider: ___________________________

Supervisor Comments: _____________________________________________________________

Root Cause Analysis

- No controls in place to eliminate or reduce the hazard. Ex: Lack of guarding, procedures, PPE, policies, proper tools/equipment, etc.
- Controls are not effective to eliminate or reduce the hazard (this includes a situation where an employee followed the policy and was still injured). Ex: Guards do not protect worker, poor housekeeping, improper tools for the job, policy or procedure not appropriate, etc.
- Training not provided or effective in preventing incident. Ex: Job not understood.
- Lack of accountability, policy is not enforced or followed by management. Ex: Supervisors do not enforce rules or procedures.
- Employee chose not to follow the policy. Ex: Misconduct, horseplay, failure to obey rules, distracted,

Corrective Actions

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<th>Completion Date/Planned Completion Date</th>
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<td>5</td>
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</tbody>
</table>

Person(s) responsible for corrective actions: ___________________________

Signature of person responsible for corrective actions: ___________________________ Date: ___________________________

Supervisor’s Signature: ___________________________ Date: ___________________________

Manager Signature: ___________________________ Date: ___________________________
Witness Report of Incident

Name: ___________________________  Job Title: ___________________________
Address: ___________________________
Date of Hire: ___________________________
Other Witnesses: ___________________________
Date of Injury: ___________________________
Time of Accident: ________ AM  PM

Describe in detail what you observed:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What was your location relative to the employee you witnessed get injured:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What tools and/or equipment were involved in the accident:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signed: ___________________________  Date: ___________________________

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Modified Duty Work Agreement
For use when employee is released for work with restrictions.

[Company Name]

You are responsible for knowing your restrictions and limitations and expected to be aware of them at all times.

Never attempt tasks that exceed your restrictions and limitations. If a question exists with regard to assigned tasks or restrictions, advise your supervisor immediately.

Remember the medical restrictions are in effect 24 hours per day. Always exercise caution in your personal time to see that the restrictions are maintained. If you have hobbies or other outside interests, consult with the treating physician on possible effects.

Please include the following information:
1. List the medical restrictions submitted by employee's doctor or attach work status form.

2. Describe the modified work employee will do for the duration of this agreement.

Name of Employee (please print)     Name of Supervisor (please print)

Signature of Employee      Signature of Supervisor

Date        Date

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# Modified Duty Work Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Hours Worked Log Breaks/Lunch</th>
<th>Primary Tasks &amp; Duties</th>
<th>Employee Comments &amp; Signature</th>
<th>Supervisor Comments &amp; Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
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<td>Monday</td>
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<td>Saturday</td>
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</table>

I clearly understand, take responsibility for and acknowledge the limitations my medical provider, Dr. ________________________________, has placed on me while participating in my company’s Modified Duty Program.

________________________________________________________                        _______________________________
Employee Signature                                              Date

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