

SCHOOL DISTRICT OF ASHLAND

Workers' Compensation Medical Treatment

EFFECTIVE: 01/01/2015

If you are injured at work, you must immediately report the incident to your supervisor.

SCHOOL DISTRICT OF ASHLAND has made a change in how work related injuries/illnesses should be treated. The following medical facilities are the preferred workers' compensation treatment center.

If you need medical treatment due to a work related injury or illness, seek treatment at:

ESSENTIA HEALTH – ASHLAND CLINIC 1625 MAPLE LN ASHLAND, WI 54806 (715) 685-7500	ST MARY'S DULUTH CLINIC 1625 MAPLE LN ASHLAND, WI 54806 (715) 685-7525
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NOTE: Use of the provider listed is voluntary and choosing to use an alternate provider that is not listed will not affect your employee benefits under state workers' compensation laws.

For a **SERIOUS INJURY OR ILLNESS** (or any treatment that should not wait until clinic hours the next day) seek immediate treatment at the nearest emergency facility. Hospitals included (but not limited to):

MEMORIAL MEDICAL CENTER 1615 MAPLE LN ASHLAND, WI 54806 (715) 685-5500
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PLEASE NOTE

This change is effective 01/01/2015.

If you have any questions regarding this procedure, please call Laura Graf at (715) 682-7080 ext. 6008.

I verify that I have received the SCHOOL DISTRICT OF ASHLAND's Workers' Compensation medical treatment information.

The injured employee is responsible for answering all questions on the Employee's Work Injury Report accurately and in detail. This will make the processing of your claim both accurate and timely. This completed report should be given to the workers' compensation contact within 24 hours of your work-related injury.

THIS FORM DOES NOT REPLACE THE FIRST REPORT OF INJURY (FROI). EMPLOYER COMPLETES THE FROI.

THE FROI IS REQUIRED BY THE STATE TO INITIATE A WORKERS' COMPENSATION CLAIM.

Employee's Work Injury Report

Personal	Name _____	Social Security Number _____
	Address _____	Birth Date _____ Sex M <input type="checkbox"/> F <input type="checkbox"/>
	City, State _____	Zip _____ Telephone _____
	Married <input type="checkbox"/> Single <input type="checkbox"/>	Number of Dependents _____ Home/School _____
	Family Physician _____	Telephone Number _____
	Are you currently entitled to Medicare Benefits? Yes <input type="checkbox"/> No <input type="checkbox"/> Medicare #(HICN) _____	
Have you applied for Medicare or SSDI? Yes <input type="checkbox"/> No <input type="checkbox"/> Pending <input type="checkbox"/> Rejected <input type="checkbox"/>		

Employment	Job Title _____	Employment Date _____
	Salary/Hourly Rate _____	Hours Worked Per Day _____
	Building Location _____	Time Work Day Begins _____

Injury/Illness	Date of Injury _____	Time of Accident _____
	Where in the facility/job site did this injury occur? _____	
	What were you doing when injured? _____	
	How did the injury occur? _____	
	Describe the injury or illness in detail and indicate the part of the body affected. (Designate right or left if appropriate.) _____ _____	
	Any previous similar injury? If yes, explain. _____	
	Was this injury witnessed? If so, by whom? _____	
	Did you lose time from work? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date(s) missed _____
Have you returned? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, what was the date? _____	

Treatment	Medical Facility _____
	Diagnosis/Care Prescribed _____

Contact	When you return to work, you must call Laura Graf at (715) 682-7080 ext. 6008 and notify your assigned claims adjuster.	
	Employee's Signature (PRINTED) _____	Date _____
	Employee's Signature _____	

SUPERVISOR'S INSTRUCTIONS

Assisting the Injured Employee

1. An employee who is injured at work must immediately report the incident to their supervisor.
 2. The supervisor is required to:
 - Obtain immediate medical attention for the injured worker: Call the physician or medical facility prior to the employee's arrival, alert the staff of the injury/illness and approximate arrival time;
 - Follow company requirement for reporting job related injuries and illnesses;
 - Complete an incident investigation report.
 3. The supervisor and injured worker review information received from the doctor and jointly determine if appropriate work is available.
 4. Following an injured workers' return to work, the supervisor or the workers compensation contact monitors the injured workers' progress to assure that restrictions are carefully followed and assist to resolve any difficulties.
 5. The injured worker must immediately report any difficulties with performing assigned work. Supervisor and injured worker work to address the problem.
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The Investigation Report

The purpose of this form is to determine what actions are needed to eliminate or control the hazards that have caused the accident. The information gathered will guide your staff in developing safety consciousness and knowledge of safe conditions and safe work methods. If you are not aware of the circumstances surrounding the injury, you should consult with the employee in order to complete the investigation report accurately.

The statements made in this report are very important and should not contain phrases as "Employee should be more careful." As the supervisor, you should make the appropriate corrective recommendations for each accident such as "Notified the appropriate employee to place caution signs in the area when floors are wet."

After you complete the investigation report, return it to the workers' compensation contact within 24 hours of the employee's work-related injury.

If you have any questions or concerns, call Laura Graf at (715) 682-7080 ext. 6008.

SUPERVISOR'S INVESTIGATION REPORT

Name of Injured Employee:	Date:
Job Title and Department:	
Date and Time Of Injury:	Type of Injury:
Medical Treatment Center:	

What was the employee doing when injured? Where in the facility / job site did the accident happen?

Describe what happened: _____

What corrective steps will be done (or could be done) to prevent recurrence? _____

Was the employee working at designated job?

Yes No

Is there modified duty available for the injured worker?

Yes No

Has the injured employee returned to work?

Yes No

If so, what date? _____

Supervisor's Signature

Date

Reviewed by Workers' Compensation Coordinator

Date

Comments:

Return completed form within 24 hours of the accident to Laura Graf.

PHYSICIAN AUTHORIZATION FORM FOR MEDICAL TREATMENT

Injured Employee's Name:	Date:
Company Name & Address: SCHOOL DISTRICT OF ASHLAND (Policy # 1H30424) 2000 BEASER AVE ASHLAND, WI 54806	Supervisor:

Do Not Use Your Group Health Membership Card if this injury/illness was sustained while working or acting in an official capacity for this company.

The following facilities are the preferred workers' compensation treatment centers. Taking this Physician's Authorization Form with you will assist the staff in your care and in processing your medical bills correctly. You should call or have someone call for you to let the physician or clinic know you are on your way for medical treatment and the nature of the injury or illness.

ESSENTIA HEALTH – ASHLAND CLINIC 1625 MAPLE LN ASHLAND, WI 54806 (715) 685-7500	ST MARY'S DULUTH CLINIC 1625 MAPLE LN ASHLAND, WI 54806 (715) 685-7525
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For a **SERIOUS INJURY OR ILLNESS** (or any treatment that should not wait until clinic hours the next day) seek immediate treatment at the nearest emergency facility. Hospitals included (but not limited to):

MEMORIAL MEDICAL CENTER
 1615 MAPLE LN
 ASHLAND, WI 54806
 (715) 685-5500

**Send all EMC work comp medical bills directly to:
 EMC Insurance Companies, PO Box 327, Brookfield, WI 53008-0327 Fax: 888-992-6125**

PLEASE NOTE
 This change is effective 01/01/2015.

If you have any questions regarding this procedure, please call Laura Graf at (715) 682-7080 ext. 6008.

 Supervisor's Signature

 Date

Work Related Injury/Illness Report

Date of Service: _____
 Patient Name: _____
 Employer: SCHOOL DISTRICT OF ASHLAND

PLEASE FAX IMMEDIATELY TO BOTH:
 ASHLAND SCHOOLS Fax: (715) 682-7097
 EMC Insurance Companies Fax: (888) 992-6125

Notified: Yes No

Diagnosis: _____ Is condition work related? Yes No

Treatment Plan: _____

Medication(s): _____

Date of most recent examination by this office: / / . The next scheduled visit is: as needed OR / / .
Month/Day/Year Month/Day/Year

1. Recommended his/her return to work with no limitations on .
Date
2. He/She may return to work on with the following limitations.
Date

DEGREE	LIMITATIONS																
<input type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as docket, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.	1. In an 8 hour work day, patient may: a. Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 4-6 Hours <input type="checkbox"/> 1-4 Hours <input type="checkbox"/> 6-8 Hours b. Sit <input type="checkbox"/> 1-3 Hours <input type="checkbox"/> 3-5 Hours <input type="checkbox"/> 5-8 Hours c. Drive <input type="checkbox"/> 1-3 Hours <input type="checkbox"/> 3-5 Hours <input type="checkbox"/> 5-8 Hours 2. Patient may use hands for repetitive: <input type="checkbox"/> Single Grasping <input type="checkbox"/> Pushing & Pulling <input type="checkbox"/> Fine Manipulation 3. Patient may use feet for repetitive movement as in operating foot controls: <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Patient is able to: <table style="margin-left: 40px; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;"><u>Frequently</u></th> <th style="text-align: center;"><u>Occasionally</u></th> <th style="text-align: center;"><u>Not at all</u></th> </tr> </thead> <tbody> <tr> <td>a. Bend</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Squat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Climb</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		<u>Frequently</u>	<u>Occasionally</u>	<u>Not at all</u>	a. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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c. Climb		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
<input type="checkbox"/> Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.																	
<input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds.																	
<input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.																	
<input type="checkbox"/> Very Heavy Work. Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.																	

OTHER INSTRUCTIONS AND/OR LIMITATIONS: _____

3. These restrictions are in effect until or until patient is reevaluated.
Date
4. He/She is totally incapacitated at this time. Patient will be reevaluated on .
Date

Treating Facility Name: _____
Please Print

Physician's Signature: _____ Phone No: () _____

RELEASE OF INFORMATION AUTHORIZATION

I authorize the treating physician to release copies of my medical records including lab and x-ray reports to the above-named employer and the insurance company. I certify that I have received a copy of this report.

Employee's Signature: _____ Date: _____