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:

<table>
<thead>
<tr>
<th>ESSENTIA HEALTH – ASHLAND CLINIC</th>
<th>ST MARY’S DULUTH CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1625 MAPLE LN</td>
<td>1625 MAPLE LN</td>
</tr>
<tr>
<td>ASHLAND, WI 54806</td>
<td>ASHLAND, WI 54806</td>
</tr>
<tr>
<td>(715) 685-7500</td>
<td>(715) 685-7525</td>
</tr>
</tbody>
</table>

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):

<table>
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<th>MEMORIAL MEDICAL CENTER</th>
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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.
### Employee’s Work Injury Report

**Personal**

- **Name:**
- **Social Security Number:**
- **Address:**
- **Birth Date:**
- **Sex:** M ☐ F ☐
- **City, State:**
- **Zip:**
- **Telephone:**
- **Married ☐ Single ☐**
- **Number of Dependents:**
- **Home/School:**
- **Family Physician:**
- **Telephone Number:**
- **Are you currently entitled to Medicare Benefits?** Yes ☐ No ☐
- **Medicare #(HICN):**
- **Have you applied for Medicare or SSDI?** Yes ☐ No ☐ Pending ☐ Rejected ☐

**Employment**

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

- **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?**

**Injury/Illness**

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 ☐ No ☐
- **Date(s) missed:**
- **Have you returned?** Yes ☐ No ☐
- **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.

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.

Form completed by the supervisor of the injured employee and saved in the injured employee’s file

EMC Insurance Companies
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

Injured employee should take completed form to initial physician’s visit
Work Related Injury/Ilness Report

Date of Service: __________________________
Patient Name: ____________________________
Employer: SCHOOL DISTRICT OF ASHLAND

Diagnosis: ________________________________

Treatment Plan: __________________________

Medication(s): ___________________________

Date of most recent examination by this office: __/__/____. The next scheduled visit is: □ as needed OR __/__/____.

1. □ Recommended his/her return to work with no limitations on ______. Date

2. □ He/She may return to work on ______ with the following limitations.

<table>
<thead>
<tr>
<th>DEGREE</th>
<th>LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying objects weighing up to 10 pounds.</td>
<td>1. In an 8 hour work day, patient may:</td>
</tr>
<tr>
<td>Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds.</td>
<td>a. Stand/Walk □ None □ 1-4 Hours □ 6-8 Hours</td>
</tr>
<tr>
<td>Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.</td>
<td>b. Sit □ 1-3 Hours □ 3-5 Hours □ 5-8 Hours</td>
</tr>
<tr>
<td>Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.</td>
<td>c. Drive □ 1-3 Hours □ 3-5 Hours □ 5-8 Hours</td>
</tr>
<tr>
<td>Very Heavy Work. Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.</td>
<td>2. Patient may use hands for repetitive:</td>
</tr>
<tr>
<td></td>
<td>□ Single Grasping</td>
</tr>
<tr>
<td></td>
<td>□ Pushing &amp; Pulling</td>
</tr>
<tr>
<td></td>
<td>□ Fine Manipulation</td>
</tr>
<tr>
<td></td>
<td>3. Patient may use feet for repetitive movement as in operating foot controls: □ Yes □ No</td>
</tr>
</tbody>
</table>

4. Patient is able to:

a. Bend □ Frequently □ Occasionally □ Not at all
b. Squat □ Frequently □ Occasionally □ Not at all
c. Climb □ Frequently □ Occasionally □ Not at all

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: ____________________________

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: __________

Page 6  Form completed by physician and faxed immediately to all parties listed in top, right-hand box.