<COMPANY INFORMATION GOES HERE>

Employee Incident Procedure Packet {FA6}

1. Report incident to your supervisor immediately.
2. Fill out the attached Employee Incident Report {FA1}.
3. If you **DO NOT NEED medical treatment** give the completed Employee Incident Report {FA1} to <*company workers comp manager*>.
4. **If you NEED medical treatment** you **MUST** give the completed Employee Incident Report {FA1} to <*company workers comp manager*> **AND** take the attached Return To Work Form {FA2} to the doctor's office, **AND** inform the medical provider that <*company name*> has a "no time loss" philosophy and can provide return to work options available for any restriction.
    a. We recommend you see (although you can see a provider of your choice):

        <*enter medical provider's name*>
        <*enter medical provider's street address*>
        <*enter medical provider's city, state, zip*>
        <*enter medical provider's telephone number*>

        <*enter medical providers hours of operation*>

    b. If the injury occurs after hours and it is medically necessary the closest emergency medical provider is:

        < enter nearest hospital emergency room>
        <*enter street address of emergency room*>
        <*enter emergency room city, state, zip*>

5. You must return to <*company name*> immediately after your doctor's appointment with the completed Return To Work Form {FA2} to <*company workers comp manager*>or, if not available, an appropriate supervisor.
6. If restricted from work, the <*company workers comp manager*> or appropriate supervisor will present you with a job offer letter {FA3} and a copy of the completed Return To Work Form {FA2} signed by the medical provider.
7. You must check in with <*company workers comp manager*> after each doctor's appointment.
8. You must schedule all treatment outside of your scheduled work periods.

I have read and understand <*company name*> incident reporting procedure listed above, **AND** I agree to follow the terms and physical restrictions of my release both at work and outside of work to help facilitate my recovery.

Employee Signature: _____ Date: _____

IMMEDIATELY SUBMIT COPY TO ERN*WEST* VIA FAX 877-717-0590 OR VIA EMAIL CLAIMSREPORTING@ERNWEST.COM

EMPLOYEE INCIDENT REPORT {FA1}

Company Name: _____ Location Name: _____

Employee:	Job Title:	Time Shift Began: AM / PM (circle)
Date of Incident:	Time of Incident: AM / PM (circle)	Reported to Employer: _____/_____/_____
Employee's Home or Mailing Address:	Home Phone: ( )	Gender: [ ] Male [ ] Female
	Date of Hire: _____/_____/_____	
	Date of Birth: _____/_____/_____	Last Full Day Worked: _____/_____/_____

Seen by:

[ ] Emergency Room [ ] Urgent Care [ ] Other

Treating Caregiver's Name, Address & Phone:

_____

_____

_____

1) Were prescription drugs prescribed? [ ] Yes [ ] No
2) Will employee lose time from work? [ ] Yes [ ] No
3) Was employee placed on modified duty? [ ] Yes [ ] No
4) Was worker hospitalized overnight? [ ] Yes [ ] No
5) Was the incident fatal? [ ] Yes [ ] No
6) If fatal, date of death ___/____/___

Describe in detail what employee was doing <u>just before</u> the incident occurred including the activity, tools, equipment, and/or material being used (e.g. employee was attempting a two person resident transfer).

_____

_____

Describe how the incident occurred, including the activity being performed and objects, people associated with the injury (e.g. resident panicked and twisted during the transfer and while attempting to safely place the resident on bed employee strained right shoulder):

_____

_____

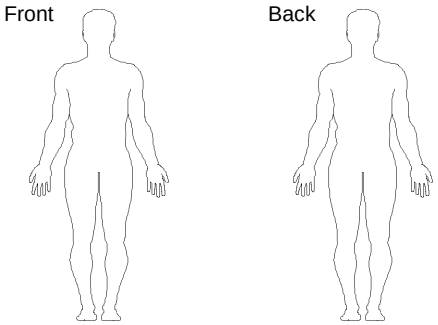
If applicable what object or substance directly harmed the employee (e.g. needle, exposure to pathogen):

_____

Part of Body (Circle side if applicable)

[ ] Head	[ ] Hand (L or R)	[ ] Knee (L or R)
[ ] Eyes (L or R)	[ ] Finger	[ ] Abdomen
[ ] Nose	[ ] Leg (L or R)	[ ] Entire
[ ] Mouth	[ ] Foot (L or R)	[ ] Glasses
[ ] Ear	[ ] Toes	[ ] Teeth
[ ] Shoulder (L or R)	[ ] Internal	[ ] Groin
[ ] Back	[ ] Multiple	[ ] Neck
[ ] Chest	[ ] Ankle (L or R)	[ ] Elbow (L or R)
[ ] Arm (L or R)	[ ] Wrist (L or R)	[ ] Rib
[ ] Hip	[ ] Face	

MARK INJURED AREA(s) BELOW



1) Rate of Pay _____ per mo/wk/hr 2) Days Worked per Week _____ 3) Hours per Week _____

4) Health Benefits **(circle)** Y or N 5) Monthly benefits (med/vision) paid $_____ per mo/wk/hr

PAYROLL Fill out this section if employee misses more than one day of work.

PART II TO BE COMPLETED BY EMPLOYEE

Was injury work related ? [ ] Yes [ ] No
I understand light work is available to me. [ ] Yes [ ] No

Employee statement of how incident occurred: _____

_____

_____

<u>MEDICAL RELEASE AUTHORIZATION:</u> I hereby authorize my physician, clinic, hospital, agency, or therapy provider to release to my employer's representative any relevant medical records regarding current or previous treatment(s) that has been furnished to me.

Employee's Signature_____ Date _____

Form Completed By: _____ Phone: _____ Date: _____ Title: _____

OSHA Log case number _____ **(transfer the case number from the OSHA 300 log after recording the case)**

Return To Work Form {FA2}

We are committed to returning our team member back to work as soon as medically possible and we need your help! Please give this document back to our employee during your visit with them, they are required to return this to us within one (1) business day so we can try and assist in their rehabilitation by providing modified work. **YOU CAN BILL FOR FILLING OUT THIS FORM BY USING L&I CODE 1074M.**

Employee: _____ Company: _____ L&I Claim No.: _____

Date of injury: _____ Today's date: _____ Return visit on _____ First injury/condition of this type? ☐ Yes ☐ No

Initial Diagnoses: _____ Estimated full-duty release date _____

Treatment Plan (check all that apply)

☐ Physical Therapy ____ times per week, for _____ weeks ☐ Occupational Therapy ____ times per week, for _____ weeks
☐ Surgery - anticipated date _____
☐ X- Ray ☐ MRI ☐ CT Scan ☐ EMG ☐ Other _____

Referral to other providers: ☐ None ☐ Neurology ☐ Orthopedic Surgeon ☐ Physiatrist/Occ. Med. ☐ Rheumatologist ☐ Other_____

We have identified four (4) stages of modified duty, unless otherwise specified here _____ (indicate # of hours per day & days per week) we are assuming this modified duty is approved for 40 hours per week. Below please check the appropriate stage to which our employee is released and feel free to cross out any task our employee should not be performing.

☐ **Stage 1:** Work at this stage would include such tasks as inspecting glasses, dishes, cutlery for cleanliness/customer safety; cleaning and filling shakers/grinders, sugar caddies; tending drink/salad/desert station(s); seating customers; greeting customers; tending bread station; operating the cash register; wrapping silverware; preparing small food items (e.g. cutting vegetables, weighing portions, preparing cook station items; setting tables, wiping down and cleaning of items (e.g. tables, menus, seats, counters, coolers).

Standing:	Occasional	**Carrying:**	1 - 5 lbs.	**Grasping/Handling:**	Frequently
Sitting:	Occasional	**Lifting:**	1 - 5 lbs.	**Bending/Squatting:**	Occasional
Walking:	Rare/Occasional	**Push/Pull:**	1 - 5 lbs.	**Twisting/Climbing:**	Rare

☐ **Stage 2:** Performing all tasks listed under "Stage 1" above as well as delivering drink orders; delivering small orders to tables; stocking dishes; washing dishes; stocking food stations; busing small tables; cleaning and arranging food coolers; mopping floors; preparing larger food items.

Standing:	Occasionally	**Carrying:**	6 – 15 lbs.	**Grasping/Handling:**	Continuously
Sitting:	Occasional	**Lifting:**	6 – 15 lbs.	**Bending/Squatting:**	Occasionally/Frequent
Walking:	Occasional	**Push/Pull:**	6 – 15 lbs.	**Twisting/Climbing:**	Occasional

☐ **Stage 3:** Performing all tasks listed under "Stages 1 and 2" above and taking out garbage; receiving food orders; arranging tables or chairs; taking orders to tables.

Standing:	Frequently	**Carrying:**	16 - 30 lbs.	**Grasping/Handling:**	Continuously
Sitting:	Rare	**Lifting:**	16 - 30 lbs.	**Bending/Squatting:**	Frequent
Walking:	Frequently	**Push/Pull:**	16 - 30 lbs.	**Twisting/Climbing:**	Frequent

☐ **Stage 4: Return to full duty no restrictions:**

DEFINITIONS

Rare: 0% - 10%

Occasional: 11% - 33%

Frequent: 34% - 66%

Constant: 67% - 100%

WAC 296-19A-030 requires doctors to respond to requested information in a timely manner, which includes physical capabilities or restrictions.

MEDICAL PROVIDER: *This form should be returned to the injured employee during their appointment to facilitate a quick return to work. If this is not possible please fax it to* ***877-717-0590*** *and it will be forwarded to the employer.*

_____ _____ _____

Doctor Signature **REQUIRED** Date Medical provider name and phone

{FA3}

____/____/____

_____

_____

_____

RE: L&I Claim # _____

Dear _____

I am pleased to offer you employment with _____which will accommodate your current physical capacities. The job is that of _____. This job is available on a reasonably continuous basis and additional modifications can be made based on objective medical findings and associated restrictions. The details of this offer are subject to all hiring and employment requirements and may include verification of employment eligibility and drug testing. A detailed description of the job which has been approved by a medical provider has been attached to this letter. The specifics of your employment include but are not limited to:

1) You will report for duty on ____/____/____ at the following address:

   _____

   _____

2) Your shift will begin at ___:____ and will end at ___:____. You will be scheduled for ____ (shift/hours) per week. This is based on your pattern of employment established prior to the date of your injury.
3) You will report to _____, who will act as your direct supervisor, and he/she has been advised of your physical capacities.
4) Your wage will be $_____ per hour and you will receive benefits in accordance with our company policy.
5) If you have additional medical appointments, you must schedule them outside of work hours unless approved by a supervisor, or scheduled by L&I.
6) As necessary, training will be provided to help satisfactorily complete assigned duties not previously performed.
7) Should you experience any difficulties in the performance of your duties; you are to report them to _____(**supervisor's name**) as soon as possible.
8) This employment relationship is at-will which means both we as the employer and you as the employee are free to end this relationship at any time with or without cause.

Should you have any questions regarding this letter, please contact me at (____)_____-_____. Please contact me by telephone no later than ____/____/____. to accept or decline this job offer.

Please check the appropriate box below and return this letter to me, by hand, or post-marked no later than ____/____/____.. If you do not contact me by____/____/____, and/or you do not show up for work on ____/____/____. your time loss benefits will most likely end.

_____ I ACCEPT THIS OFFER

_____ I DECLINE THIS OFFER (may affect L&I time loss benefits)

_____

Employee's Signature Date

Sincerely,

Encl.: Approved Job Analysis
Cc: Claims Manager, ERNWest, Vocational Counselor, Attending Doctor