ATTENTION ALL EMPLOYEES

PARKVIEW SCHOOL DISTRICT

Workers' Compensation Medical Treatment

EFFECTIVE: Immediately

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

Parkview School District has made a change in how work related injuries/illnesses should be treated. The following medical facility is the preferred workers' compensation treatment center.

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

MERCY CLINIC SOUTH
849 KELLOGG AVE #1C
JANESVILLE, WI 53546
(608) 755-7960

NOTE: Use of the providers 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.

EMERGENCY CARE: For a *LIFE THREATENING or SERIOUS INJURY*, call 911 immediately and seek immediate treatment at the nearest emergency facility.

If you have any questions regarding this procedure, please call Tracy Case at (608) 879-2717 ext 6113.

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I verify that I have received Parkview School District's Workers' Compensation Medical Treatment Information.

Employee's Signature (PRINTED)

Employee's Signature

Date

Form should be signed by all current/new employees and saved in employee's personnel file

EMC Insurance Companies

Employee's Work Injury Report

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.

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 _____

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 ☐ 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 Tracy Case at (608) 879-2717 x 6113 and notify your assigned claims adjuster.

Employee's Signature (PRINTED) _____ Date _____

Employee's Signature _____

Form completed by injured employee (as soon after the injury as possible) and given to Workers' Comp. contact

EMC Insurance Companies

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 Tracy Case at (608) 879-2717 ext 6113.

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 Tracy Case

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: PARKVIEW SCHOOL DISTRICT PO BOX 250 ORFORDVILLE, WI 53576 POLICY # 4X77523	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 facility is the preferred workers' compensation treatment center. 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.

MERCY CLINIC SOUTH
849 KELLOGG AVE #1C
JANESVILLE, WI 53546
(608) 755-7960

NOTE: Use of the providers 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.

EMERGENCY CARE: For a *LIFE THREATENING or SERIOUS INJURY*, call 911 immediately and seek immediate treatment at the nearest emergency facility.

Send all EMC work comp medical bills directly to:
EMC Insurance Companies, PO Box 327, Brookfield WI 53008-0327 Fax: 888.992.6125

If you have any questions regarding this procedure, please call Tracy Case at (608) 879-2717 ext 6113.

Supervisor's Signature

Date

Injured employee should take completed form to initial physician's visit

EMC Insurance Companies

Work Related Injury/Illness Report

PLEASE FAX IMMEDIATELY TO BOTH:
Parkview School District Fax: (608) 879-2732
EMC Insurance Companies Fax: (888) 992-6125

Date of Service: _____
Patient Name: _____
Employer: **PARKVIEW SCHOOL DISTRICT** 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

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, 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.

☐ **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.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds.

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Very Heavy Work.** Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.

LIMITATIONS

1. In an 8 hour work day, patient may:

a. Stand/Walk	☐ None	☐ 4-6 Hours	
	☐ 1-4 Hours	☐ 6-8 Hours	
b. Sit	☐ 1-3 Hours	☐ 3-5 Hours	☐ 5-8 Hours
c. Drive	☐ 1-3 Hours	☐ 3-5 Hours	☐ 5-8 Hours

2. Patient may use hands for repetitive:
☐ Single Grasping
☐ Pushing & Pulling
☐ Fine Manipulation

3. Patient may use feet for repetitive movement as in operating foot controls: ☐ Yes ☐ No

4. Patient is able to:

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

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: _____

EMC Insurance Companies