WORKERS' COMPENSATION

West Bend

Manager Form ☐
*Required. Turn into HR.

Employee Accident Form ☐
*Required. Turn into Manager. Manager sends to HR.

Witness Form ☐
*Optional. Send to HR if there was a witness.

Attending Physician Form ☐
*Required if seeing a doctor. Give to a physician.

Medical Card ☐
*Optional. Medical card is available if prescriptions or immediate payment is required.

List of Pharmacies ☐
*Optional. These are covered pharmacies. Additional pharmacies must be approved by West Bend.

Temporary Work Form ☐
*Optional. Complete if employee returns to work with temporary work duties (ex. work in office)

Please report accidents immediately to Anne Ziola, Director of Human Resources.

All material should be returned to HR or
submitted via email to humanresources@doane.edu
Call 402.826.6795 with questions.

Management Accident Investigation Report

To Be Completed By One Of The Following: Supervisor / Plant Manager / HR Director

Employee	Dept.	Job Title
Shift:	Date of Injury Time AM or PM	
Location of Incident		
Date Reported / / Time Reported	Reported to Whom?	

NAME OF WITNESS	DEPARTMENT/ADDRESS	PHONE
(1)		
(2)		

Have witnesses fill out separate forms and give attach.

1. What was employee doing when injured? BE SPECIFIC

2. How did the injury/illness occur?

3. Was employee performing function alone? ☐ yes ☐ no

Employee was assisting with the operations?

4. Did injury occur because of: Failure to follow safety rules ☐

Failure to use safety device ☐ Other ☐

5. How long has employee been doing this job? (days, months, years)

6. What safety equipment is required on the job the employee was performing?

7. Was the employee using all required safety equipment? Yes ☐ No ☐

8. If No, which specific personal protective equipment was not used & why?

9. Does an unsafe condition exist that contributed to the cause, if so, what is that condition?

10. How could the accident have been prevented? BE SPECIFIC

RECOMMENDED ACTION			**Person Responsible**	**Assigned Date/Completed Date**
Re-instruction	Yes ☐	No ☐	_____	_____/_____
Equipment repair/replacement	Yes ☐	No ☐	_____	_____/_____
Reduce Clutter	Yes ☐	No ☐	_____	_____/_____
Improve design/construction	Yes ☐	No ☐	_____	_____/_____
Workstation Modification	Yes ☐	No ☐	_____	_____/_____
Discipline of person(s) involved	Yes ☐	No ☐	_____	_____/_____
Other				

Signature of Person Completing Investigation: _____

Date: _____

Employee Accident Report

Name: _____ Accident Location: _____

Date of Injury: _____ Time: _____ a.m. ☐ p.m. ☐ Date Reported: _____

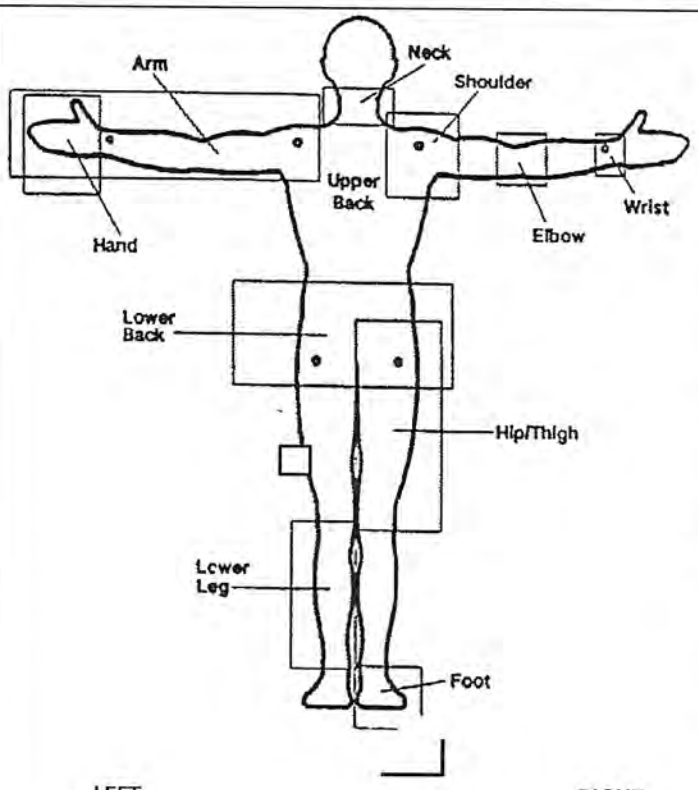
Witnesses: _____

Accident Description: _____

_____

_____

_____

Injured Area	Indicate Area of Injury	Type of Injury
1 ☐ Head 2 ☐ Eye: L / R 3 ☐ Shoulder L / R 4 ☐ Arm L / R 5 ☐ Elbow L / R 6 ☐ Wrist L / R 7 ☐ Hand L / R 8 ☐ Finger: Specify _____ 9 ☐ Back 10 ☐ Chest 11 ☐ Abdomen 12 ☐ Pelvis 13 ☐ Hip L / R 14 ☐ Leg L / R 15 ☐ Knee L / R 16 ☐ Ankle L / R 17 ☐ Foot L / R 18 ☐ Toe: Specify _____ 19 ☐ Other: _____ _____		1 ☐ Abrasion 2 ☐ Amputation 3 ☐ Bite: _____ 4 ☐ Bruise 5 ☐ Burn 6 ☐ Concussion 7 ☐ Cut / Laceration 8 ☐ Foreign Body 9 ☐ Fracture 10 ☐ Hearing Impaired 11 ☐ Infection 12 ☐ Pain: _____ _____ 13 ☐ Puncture 14 ☐ Rash/Derm. 15 ☐ Respiratory 16 ☐ Strain/Sprain 17 ☐ Other: _____ _____ _____

Have you ever injured this body part before? _____ if so, when? _____

Are you currently receiving medical treatment for the prior injury? _____

What do you believe caused this accident? _____

What can be done to prevent this from happening in the future? _____

_____

Signature: _____

Date: _____

WITNESS REPORT OF INCIDENT

Name: _____ Injured Employee Name: _____

Date of Injury: _____ Time of Accident: _____ (AM/PM)

Location where injury occurred:

_____

_____

_____

Describe activity prior to the accident:

_____

_____

_____

Describe the accident:

_____

_____

_____

What do you believe caused the accident:

_____

_____

_____

What part of the body was injured? _____

What do you think could prevent this type of accident from occurring again?

_____

_____

_____

Signed: _____ Date: _____

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THE SILVER LINING™

MEDICAL UPDATE

Claim number	Patient's Name	Date of Injury/Illness

TO BE COMPLETED BY ATTENDING PHYSICIAN

Relevant Diagnosis/Condition (Brief Explanation)

_____

_____

Evaluation completed on _____ and based on the current diagnosis/condition:

1. Recommend full capabilities on _____ (date).
2. Patient may return to the following physical capabilities, checked below on _____ (date).

PHYSICAL CAPABILITIES (WORK AND HOME)

☐ **Sedentary activities:** Sitting most of the time, may involve walking or standing for brief periods.

☐ **Very light activities.** Very light lift/carry-10 lbs. maximum.

☐ **Light activities.** Lift/carry 10 lbs. frequently and occasionally up to 20 lbs.

☐ **Medium activities.** Lift/carry 25 lbs. frequently. Occasionally up to 50 lbs.

☐ **Medium heavy activities.** Lift/carry 40 lbs. frequently and occasionally up to 75 lbs.

☐ **Heavy activities.** Lift/carry 50 lbs. frequently and occasionally up to 100 lbs.

Address following if applicable to work injury

Stand/walk

☐none ☐1-4 hrs. ☐4-6 hrs. ☐6-8 hrs. ☐unrestricted

Sit

☐1-3hrs. ☐3-5 hrs. ☐5-8 hrs. ☐unrestricted

Drive

☐none ☐1-3 hrs. ☐3-5 hrs. ☐5-8 hrs. ☐unrestricted

Patient may use hand(s) for repetitive:

☐Simple grasping ☐ Pushing & Pulling

☐Fine manipulation

Patient may use foot/feet for repetitive movement as in operating foot controls:

☐Yes ☐ No

	Frequently	Occasionally	Not At All
Bend	☐	☐	☐
Squat	☐	☐	☐
Climb	☐	☐	☐
Twist	☐	☐	☐
Reach	☐	☐	☐
Overhead work	☐	☐	☐

Other instructions:

_____.

3. These capabilities are in effect until _____ or until reevaluation on_____.

TX plan: (fax all orders to 888-926-9299)

PT/OT: Yes ☐ No ☐ DME ordered: Yes ☐ No ☐

Diagnostics ordered: Yes ☐ No ☐ Medications ordered: Yes ☐ No ☐

Has MMI been reached Yes ☐ No ☐ If not, when do you anticipate MMI: _____

Physician Name (Printed)	Facility Name and Phone Number
Physician's Signature	**Date** **Phone # :**

Workers' Compensation Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed the processing of your approved workers' compensation prescriptions.

You will receive a permanent prescription card when the claim is received by the insurance carrier.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame a la Atención a Clientes en myMatrixx, una compañía de Express Scripts, al 877-804-4900.

To the Pharmacist:

myMatrixx, an Express Scripts Company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of $350. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____/_____/_____
MM/DD/YYYY

Group #: P4UA _____

Employee Date of Birth: _____/_____/_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

Participating Retail Network Pharmacies

myMatrixx
An Express Scripts Company

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Walmart
Wegmans
Weis
Winn Dixie

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A MUTUAL INSURANCE COMPANY™

Temporary Work Schedule

DEFINITION: A form used by an employee returning to work in the Temporary Work Program.

POLICY

Every employee returning to temporary restricted work duty must use a Temporary Work Schedule. It is the employee's immediate supervisor's responsibility to thoroughly explain the use of the Temporary Work Schedule. The Temporary Work Schedule must be completed daily.

The temporary tasks assigned to you may or may not be normal and customary job duties.

The **employee's responsibility** to complete:

- Restrictions
- Symptom Control Techniques
- Date
- Hours Worked - Log Breaks, Rest and Lunch
- Duties Performed
- Employee Comments
- Employee Signature

The **supervisor's responsibility** to complete:

- Supervisor's Comments (document discussion of problems and actions taken)
- Supervisor's Signature

*The supervisor and employee must sign schedule daily.

Supervisors turn Work Schedule into Human Resources Department at end of week.

Employee should retain a copy for their file.

The Human Resources Department will forward copy to the Claims Representative and, if necessary, to treating physician

NOTICE OF EMPLOYEE'S RIGHT TO CHOOSE A DOCTOR

NOTICE TO EMPLOYER: *Give this form to the injured worker as soon as possible* ***AFTER*** *each injury.*

EMPLOYEE MAY CHOOSE

When you are injured at work, you may have the right to choose a doctor to treat you.

If your employer gives you notice of this right following the accident, your choice of doctor is limited to a doctor who has treated you or an immediate family member before the injury.

- You must choose as soon as possible after your employer gives you this notice.
- If you have such a doctor and want that doctor to treat you for your work injury, you must tell your employer the name of the doctor.
- You can use the *Choice of Doctor Designation Form* below to record the name of the doctor you choose.
- Immediate family members are your spouse, children, parents, stepchildren, and stepparents.
- If your employer asks, you or your family member must give your employer written permission to verify prior treatment.

If it is an emergency, get the treatment you need, then tell your employer the name of your doctor.

You may choose any doctor to perform major surgery or an amputation, if that treatment is recommended.

Once you choose your doctor, you may not change doctors unless your employer agrees or the Nebraska Workers' Compensation Court orders a change. A referral made by the chosen doctor is not a change.

If your claim is denied, you may choose any doctor. You will be responsible for the medical bills unless your employer is later found liable for the claim.

If you choose a doctor outside the community where you live or work, and a doctor is available in a closer community, you will not receive mileage reimbursement.

EMPLOYER MAY CHOOSE

If you were notified, but do not choose a doctor who treated you or a family member before the accident, YOUR EMPLOYER HAS THE RIGHT TO CHOOSE YOUR DOCTOR.

If you were notified, but you or your family member do not give permission for your employer to verify prior treatment with the doctor you choose, YOUR EMPLOYER HAS THE RIGHT TO CHOOSE YOUR DOCTOR.

EMPLOYEE CONFIRMATION OF NOTICE

My employer has informed me of the right to choose a doctor.

_____
[EMPLOYEE NAME]

_____
[EMPLOYEE SIGNATURE]

_____
[DATE OF NOTICE]

EMPLOYER CONFIRMATION OF NOTICE

I have informed my employee of the right to choose a doctor.

_____
[EMPLOYER REPRESENTATIVE NAME]

_____
[EMPLOYER REPRESENTATIVE SIGNATURE]

_____
[DATE OF NOTICE]

CHOICE OF DOCTOR DESIGNATION FORM

I choose the following doctor to treat me for the work-related injury I had on _____ [DATE OF INJURY]. I certify that this doctor has treated me or an immediate family member before the work-related injury.

_____
[DOCTOR NAME]

_____
[DOCTOR ADDRESS, IF KNOWN]

_____
[EMPLOYEE SIGNATURE]

_____
[DATE]

OR (Indicate your reason(s) for not choosing a doctor)

☐ I do not have a doctor who has treated me or an immediate family member before this injury.

☐ I have received notice of my right to choose a doctor, but I do not wish to choose a doctor who has treated me or an immediate family member.

_____
[EMPLOYEE SIGNATURE]

_____
[DATE]