Catholic Diocese of Sioux Falls

WORKERS' COMPENSATION CHECKLIST

FIRST REPORT OF INJURY – EMPLOYEE SEEKING TREATMENT

This checklist is for managers to use for employees who wish to seek outside medical treatment with a physician or medical provider. (Injuries other than an Incident Only/First Aid; i.e. minor scrapes, cuts, abrasions etc. that do not require off sight medical treatment). *If it is an Incident Only Claim, please complete the First Aid/Incident Only Form and follow the procedure that corresponds with Incident Only/No Treatment Sought.*

AFTER the scene of the accident has been secured:

- ☐ **1) Call the Catholic Diocese HR Office immediately**:
  Renee Leach at (605)988-3752 or Twila Roman at (605)988-3741

- ☐ **2)** Have employee read and sign **HIPAA release**.

- ☐ **3)** Make sure injured employee has the **doctor's packet.**

- ☐ **4) Complete Accident Investigation form.** This document must be completed in detail. The person reading it should be able to tell exactly how and what happened. **This form will ACCOMPANY the First Report of Injury to the Insurance Carrier/Adjuster.**

  A. Be **SPECIFIC** with your answers. (Write **FACTS,** not your opinions)
  B. Note the body part injured. Be Specific and use the Body Diagram on the form.
  C. Be sure to note any "weather" conditions that may have contributed to the injury, and where the hazard is located.
  D. Note if the injury was due to a faulty/damaged tool, object, etc.
  E. **DO NOT** investigate from your "desk."

- ☐ **5) Complete First Report of Injury.** *(Be sure to use the State Appropriate Form.)*

  A. Be **SPECIFIC** with your answers. (Write FACTS**,** not your opinions).
  B. What body part was injured? Be SPECIFIC:
     - Right or Left? Low Back or Upper Back? Neck or Shoulder etc.
     - Where exactly on the body part? Upper Rt arm, Lower Rt arm, etc.
     - Basically, write a verbal picture on FROI. (First Report of Injury)

- ☐ **6)** Have the Employee read and sign the **Injured Worker Responsibility Form.**

- ☐ **7) IF applicable, have ALL witnesses complete a Witness Report.** (Make copies of form if necessary.) Keep witnesses in separate areas when completing. This is NOT a "group project."

- ☐ **8) Read the Witness Report** to verify that it is complete – **SIGNED & DATED**.

- ☐ **9) Let injured employee know he/she needs to bring back medical information** (Work Ability Report – aka WAR form) after being treated unless admitted to the hospital.

Catholic Diocese of Sioux Falls

Workers' Compensation

The Catholic Diocese of Sioux Falls is insured for Workers' Compensation with **Accident Fund Insurance Company of America, effective 7/1/2016.** Our Workers' Compensation Insurance Agency (Agents) is/are with Howalt McDowell Insurance, a Marsh & McLennan Agency. *Our Policy Number is WCV6130319*

If/when there is a work related incident or injury, please refer to the Catholic Diocese of Sioux Falls ***"Workers' Compensation Grab-N-Go" kit/folder***.

If you receive questions pertaining to a claim number/policy number or where to send bills:

Accident Fund Insurance Company of America: Policy Number WCV6130319
Claim Verification & Billing Questions: (866-206-5851) 8:00am EST to 5:45pm EST (M-F)
Bills & Notes Fax: (517)316-2747 | *Bills & Notes Email*: documentimaging@accidentfund.com
Billing Address: Accident Fund Insurance Company of America
PO Box 40790 Lansing, MI 48901-7990

Medical Only Adjuster (No Lost Time or PPD Anticipated):
Pamela Munson, Medical Only Claims Specialist | Claims
Office: (517)708-5593 | Fax: (517)367-6767
Pamela.Munson@accidentfund.com

Indemnity Adjuster (Lost Time / PPD Anticipated / Litigated – Elevated Claim)
Elizabeth Gerhart, Senior Claims Representative
Office: (517)708-5884 | Fax: (866)293-8596
Elizabeth.Gerhart@accidentfund.com

If you need/require additional assistance/direction, please feel free to contact our Claims Advocate at Howalt McDowell Insurance:

Tanya D. Schlenker, CISR/SDWCS
Sr. Claims Consultant/Advocate
Howalt McDowell Insurance, a Marsh & McLennan Agency
Office/Cell: (605)366-1841 (24/7)
Tanya.schlenker@marshmma.com
***If you are unable to reach Tanya directly, please leave a voice mail for a return call, or if an emergency, please call (605)339-3874.*

Howalt McDowell Insurance Agents/Representatives
Bill Townsend, Risk Management Consultant | 605-274-7149 bill.townsend@marshmma.com
Allen Schlenker, Risk Management Consultant | 605-274-7134 allen.schlenker@marshmma.com
Kathy Dains, Client Advisor | 605-274-7107 kathy.dains@marshmma.com
Tanya Schlenker, Senior Claims Consultant/Advocate | 605-366-1841 tanya.schlenker@marshmma.com

SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION

DIVISION OF LABOR AND MANAGEMENT

Tel: 605.773.3681 dlr.sd.gov

FIRST REPORT OF INJURY

GENERAL INSTRUCTIONS

EMPLOYEE

1. Notify employer immediately of injury, as required by SDCL 62-7-10.
2. Complete all questions in the EMPLOYEE and INJURY/TREATMENT sections.
3. Sign the form.
4. Submit this form to your employer within three (3) business days after the injury.

EMPLOYER

1. Complete all questions in the EMPLOYER/EMPLOYMENT sections.
2. Sign the form.
3. Submit this form to your workers' compensation insurance carrier within seven (7) days of knowledge of the occurrence of the injury, as required by SDCL 62-6-2.
4. Give a copy of the form to the injured employee.
5. Keep the copy of the First Report of Injury for at least four (4) years from the date of injury, as required by SDCL 62-6-1.

BODY PART CODES

02	Blindness one eye	44	Chest, including ribs sternum, soft ribs	78	Ring finger at metacarpal bone
03	Blindness both eyes	48	Internal organs-other than heart, lungs	79	Ring finger at proximal joint
04	Deafness both ears	49	Heart	80	Ring finger at middle joint
05	Deafness one ear	51	Hip	81	Ring finger at distal joint
10	Multiple head injury	52	Upper leg	82	Little finger at metacarpal bone
11	Skull	53	Knee	83	Little finger at proximal joint
12	Brain	54	Lower leg	84	Little finger at middle joint
13	Ear(s)	55	Ankle	85	Little finger at distal joint
14	Eye(s)	56	Foot	86	Great toe metatarsal bone
17	Mouth	57	Toe (other than greater)	87	Great toe at proximal joint
19	Face (facial bones)	58	Toe (greater)	88	Great toe at distal joint
20	Multiple neck injury	60	Lungs	90	Multiple injury
21	Vertebrae	61	Groin	92	Other toe metatarsal bone
22	Disc	67	Thumb metacarpal bone	93	Other toe at proximal joint
24	Other	68	Thumb at proximal joint	94	Other toe at middle joint
31	Upper arm	69	Thumb at distal joint	95	Other toe at distal joint
32	Elbow	70	Index finger at metacarpal bone	96	Little toe metatarsal bone
33	Lower Arm-forearm	71	Index finger at proximal joint	97	Little toe at distal joint
34	Wrist	72	Index finger at middle joint		
35	Hand	73	Index finger at distal joint		
37	Thumb	74	Middle finger at metacarpal bone		
38	Shoulder	75	Middle finger at proximal joint		
41	Upper Back	76	Middle finger at middle joint		
42	Lower Back	77	Middle finger at distal joint		

Cause of Injury Codes

01	Body reaction/over reaction (includes chemicals)	70	Striking against or stepping on
03	Temperature extremes	78	Struck or injured by moving parts of machine
13	Caught in/under/between	81	Struck or injured, includes knife or sharp object, kicked, bit, etc. – struck by object, worker, patient, etc.
25	Fall from elevation	89	Hostile attack-person in act of crime
29	Fall from same level	90	Other than physical cause of injury
50	Motor vehicle	94	Repetitive motion – callous, blister, etc.
56	Bending/Lifting	97	Repetitive motion-carpal tunnel syndrome, etc.
65	Machinery/Equipment	99	Other

Nature of injury codes

00	Not applicable
01	Allergy
02	Disfigurement
71	Occupational disease
72	Hearing loss

South Dakota Employer's First Report of Injury

EMPLOYEE

SSN: _____ Date of Birth: _____ Gender: M ◯ F ◯ Dependents: _____

Name: (Last) _____ (First) _____ (Middle initial) ___

Mailing Address: _____

City: _____ State: _____ Zip: _____ Telephone No.: _____

Employee signature: (X) _____ Date _____

Education:

- ☐ Less than High School
- ☐ GED or High School
- ☐ Beyond High School

INJURY/TREATMENT

Date of Injury: _____ Time of Injury: _____ a.m. ☐ p.m. ☐ Fatality Date (if applicable): _____

County Where Injury Occurred: _____ Was Safety Equipment Provided? Yes ☐ or No ☐

Time Work Day Began on Date of Injury: _____ a.m. ☐ p.m. ☐ Was Safety Equipment Used? Yes ☐ or No ☐

Date Returned to Work (if applicable): _____ Did Injury Occur on Employer Premises? Yes ☐ or No ☐

Address or Location of Injury: _____

Description of Injury:

(See Codes on Second Page)

Body Part Injured

(If code 90, Multiple Injury, please specify body part codes for each body part injured.)

Nature of Injury

Cause of Injury

Date Employer Notified of Injury: _____

Injury Reported to: _____ Witness: _____

TREATMENT

Type of Treatment (please check one)

- ☐ No Treatment
- ☐ On-Site Treatment
- ☐ Clinic
- ☐ Emergency Room
- ☐ Hospitalization

If treatment sought, please specify provider of treatment:

Medical Practitioner, Clinic or Hospital Name: _____

Mailing Address: _____

City: _____ State _____ Zip _____

Telephone No. : _____

EMPLOYER/EMPLOYMENT INFORMATION:

Federal ID No.: _____ # Employees: _____

Employer Name (DBA): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone No. : _____ County Where Employer Located: _____

Employer signature: _____ Date _____

Employment Type: ☐ Regular or ☐ Temporary

Emp. Status: ☐ FT ☐ PT ☐ Seasonal ☐ Volunteer

Date Employee Hired: _____

Employee's Position: _____

Employee's Time in Current Position: _____

Employee's Hours Per Week: _____

Employee's Current Wage:

$ _____ per _____

CLAIM OFFICE INFORMATION

NAICS for Employer Being Insured (Nature of Business): _____

Carrier Code _____ FEIN (Claim Office) _____

Claim Office Accident Fund Insurance Company of America

Claim Office Address PO Box 40790

City Lansing State MI ZipCode 48901-7990

Telephone 866-206-5851

Email Address _____

Claim Office Claim # _____

Date Notified _____ Date to DOL _____

☑ Check if Claim Office is same as Insurance Provider

If not, you must complete the following

UNDERLYING INSURANCE PROVIDER INFORMATION

Carrier Code (If applicable) _____ FEIN (Insurance Provider) _____

Represented Entity Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

Policy Number WCV6130319

Effective Dates 7/1 Policy Year

Adjuster/Contact Person _____

For information regarding the Workers' Compensation System please visit www.sdjobs.org

Catholic Diocese of Sioux Falls

INJURY MANAGEMENT PROGRAM
Injured Workers' Responsibilities – South Dakota

As your employer, we are concerned about your full recovery. Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the State of South Dakota workers' compensation laws. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

RESPONSIBILITIES OF THE INJURED WORKER:

SDCL 62-4-43 states that you can make the initial selection of a medical doctor or surgeon from among all licensed medical practitioners or surgeons in the state**. You MUST notify us of your choice of medical doctor/surgeon prior to seeking treatment, or immediately thereafter**. This statute also places limitations on your right to change primary health care providers. Discuss with your employer/carrier any change in health care provider.

Attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks, unless otherwise indicated/explained by your treating physician. Failure to have current medical support for disability may result in termination of benefits. **Schedule your next appointment immediately after your doctor visit, before you leave the clinic if possible.**

Obtain a *Report of Workability* from your physician at every appointment. SDCL 62-4-45 requires that your physician cooperate with providing information regarding your injury, which under our policy includes return to work planning and that you be released to return to work at the earliest appropriate time.

Immediately following your appointment, provide a copy of the *WorkAbility Report* to your Manager/Supervisor, who in turn will provide a copy to the Catholic Diocese of Sioux Falls HR Office. You should deliver this in person if possible, so that changes in work restrictions may be addressed and any questions answered. If you are unable to provide a copy in person, the *WorkAbility Report* should be emailed or texted as soon as possible.

Follow all physical restrictions **at home AND at work**.

Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

Maintain regular, weekly, communication with your employer if you are unable to return to work. Contact your manager/supervisor a minimum of after every visit with your primary health care provider. **Keep the claims representative advised of your status.**

Notify your employer immediately of any new injuries or conditions that impact your physical condition.

IF it is necessary to miss scheduled work due to a work injury, you must be seen by your primary health care provider the same day. The physician must complete a Report of Workability.

I have read my responsibilities and agree to abide by these guidelines.

Employee Signature: _____

Employee Printed Name: _____

Employer Representative: _____

WORKERS COMPENSATION
WITNESS STATEMENT FORM

1. INJURED WORKER

Injured Workers' Name_____

2. WITNESS DETAILS

Name: _____ **Occupation:** _____

Address: _____

Phone: _____ **Employer's Name:** _____

Relationship to the injured worker: Co-worker____ Family _____ Other_____
If "other" – please specify: _____

3. INCIDENT DETAILS

Date of Incident: _____**Time of Incident**_____
Place of Incident: _____
Type of Injury: *(e.g. burn, cut, fracture)* _____
Location of Injury: *(e.g. rt arm, low back)* _____
Were you an eye witness? Yes_____ No_____

If "Yes", please describe what you witnessed: _____
_____
_____
_____
_____
_____
_____
_____
_____

4. DECLARATION

Please note that any person who fraudulently obtains or fraudulently attempts to obtain any benefits under Workers' Compensation, by malingering or making false claim or statement, and any person who, by a false statement or other means, aids or abets a person in so obtaining or attempting to obtain, commits an offense.

I declare that the details submitted are true and correct.

_____ _____
Signature of Witness Date

Catholic Diocese of Sioux Falls

HIPPAA Privacy Authorization
For Disclosure of Protected Health Information

Patient's /Claimant's Name: _____ SSN: _____

Address: _____Date of Birth: _____

1. This Authorization is directed to and applies to protected health information maintained by: (Hospital, Physician, Medical Provider, etc.): Any and all medical providers, physicians, and/or medical treaters.
2. I hereby authorize the above, its director, administrative and clinical staff or assignees, medical information services and billing departments to release any and all medical records and information from my date of birth to the present unless specified otherwise, relating to my care and treatment including x-rays, photographs, electronic and digital files and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records, if any, relating to treatment for alcohol, drug abuse, psychiatric/psychological services and social work records and any information regarding communicable diseases and infections.
3. This information is to be released to: ***Catholic Diocese of Sioux Falls' Work Comp Attorney/Agent, and or its insurance carrier, Accident Fund Insurance Co. of America.***
4. Further, I authorize the hospital, physician or medical provider named in Paragraph 1 hereinabove, and his/her/its director, administrative and clinical staff or assignees to discuss and disclose to the person(s) named in Paragraph 3 hereinabove and/all of my medical information, records and services authorized under Paragraph 2 hereinabove.
5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.
6. I understand that I have the right to revoke this authorization at any time, I understand that if I revoke this authorization I must do so in writing and send it to the hospital, doctor or other custodian of medical information. I understand that the revocation will not apply to information that has already been released in response to this authorization.
7. I understand that authorizing the release of this health information is voluntary and that I need not sign this form in order to ensure health care treatment, eligibility for benefits, payment or health plan enrollment.
8. A copy of this authorization is as valid as the original.

ALL PERTINENT SECTIONS OF THIS FORM MUST BE COMPLETED BEFORE SIGNING

_____ _____

Date Signature of Patient

_____

Printed Name of Patient

CATHOLIC DIOCESE OF SIOUX FALLS

WORKERS' COMPENSATION

"DOCTOR'S PACKET"

RETURN TO WORK

WORKABILITY REPORT/DOCUMENT

****Employee** – Please give this packet to your treating physician and request that he read the *Return to Work Letter* and complete the attached *WorkAbility Report*. Please return the *WorkAbility Report* to your employer/manager the same day of your appointment/examination. You can return the completed forms in person or via email/fax/text.

Catholic Diocese of Sioux Falls

ATTENTION: Treating Physician

CATHOLIC DIOCESE OF SIOUX FALLS
LIGHT DUTY-RETURN TO WORK PROGRAM

The Catholic Diocese of Sioux Falls is committed to providing a solid working environment for our employees. In the event of a staff work related injury that prohibits the injured employee from returning to their regular assigned work position and/or some of their assigned duties, it is our desire to provide temporary, alternative work placement for our staff. Whenever possible, we attempt to return an injured employee to their regular work position, providing accommodations necessary to meet the restriction. At times we have found it necessary to temporarily place an injured employee in an alternative work placement, per the recommendations of the treating physician.

As such, the Catholic Diocese of Sioux Falls will make every attempt to accommodate any restrictions you, as their primary treating physician, deem necessary, in an effort to allow our employee to fully recover from their work-related injury. These restrictions/accommodations may include, but are not limited to, lifting, bending, sitting, pushing, pulling, squatting, climbing, gripping, etc.

We ask that you complete the attached *WorkAbility Report* form and return it with the injured employee to their location of employment. Upon receipt of this form, we will review and accommodate these restrictions to the best of our ability. ***If you have concerns relating to alternative job placement and/or light duty placement, we encourage you to contact our company to discuss these issues. You may contact the Catholic Diocese of Sioux Falls Human Resources Office: Renee Leach at (605)988-3752 or Twila Roman at (605)988-3741, Monday through Friday 8:30 a.m. to 5:00 p.m.*** If unable to reach the office, please leave a message as to when it would be most convenient to return your call.

We thank you for your cooperation in assisting our injured employees to return to work. It is our belief that returning an injured employee to work requires a team effort and we appreciate your assistance.

Sincerely,

Renee Leach | Twila Roman
Office of Human Resources
Catholic Diocese of Sioux Falls

WORK ABILITY/RETURN TO WORK (Please complete form fully) – Catholic Diocese of Sioux Falls

NOTE TO EMPLOYEE: You must immediately provide a copy of this report to: Your Supervisor/Manager & the Catholic Diocese of Sioux Falls HR Department (Renee Leach / rleach@sfcatholic.org or Twila Roman / troman@sfcatholic.org)

EMPLOYEE	SS #	SUPERVISOR	DEPARTMENT

JOB TITLE	DATE OF INJURY / ILLNESS

DIAGNOSIS	ICD-9 CODE

History and Findings:

Work related injury/illness? ☐ No ☐ Yes ☐ To be determined Permanent partial disability? ☐ No ☐ Yes If Yes, _____%

Any pre-existing conditions affecting this injury/illness? ☐ No ☐ Yes If Yes, describe:

Maximum medical improvement reached? ☐ No ☐ Yes Date reached: _____

RETURN TO WORK

☐ Return to work with **no limitations** on ___/___/___ (MO DAY YR)

☐ Return to work **with limitations** on ___/___/___ through ___/___/___ if manager can accommodate.

☐ **Unable** to work from ___/___/___ through ___/___/___

Restrictions apply to home environment? ☐ Yes ☐ No If no, explain _____

EMPLOYEE'S CAPABILITIES

From: ☐ PMD _____ Dated: _____ ☐ IME _____ Dated: _____

BODY PART AFFECTED: ☐ Left ☐ Right ☐ Both ☐ Neck ☐ Upper Back ☐ Lower Back ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Leg ☐ Knee ☐ Ankle ☐ Foot ☐ Other _____

	NOT AT ALL	OCCASIONAL 0-33%	FREQUENT 34-66%	CONTINUOUS 67-100%
Lift/Carry				
0-09 lbs	☐	☐	☐	☐
10-19 lbs	☐	☐	☐	☐
20-29 lbs	☐	☐	☐	☐
30-39 lbs	☐	☐	☐	☐
40-49 lbs	☐	☐	☐	☐
No lift from floor	☐	☐	☐	☐
Push/Pull without resistance:				
0-19 lbs	☐	☐	☐	☐
20-40 lbs	☐	☐	☐	☐
> 49 lbs	☐	☐	☐	☐

	NOT AT ALL	OCCASIONAL 0-33%	FREQUENT 34-66%	CONTINUOUS 67-100%
Bend	☐	☐	☐	☐
Twist/turn	☐	☐	☐	☐
Kneel/squat	☐	☐	☐	☐
Stand/walk	☐	☐	☐	☐
Ladder/stair climb	☐	☐	☐	☐

HAND, WRIST AND SHOULDER ACTIVITIES AVOID PROLONGED, REPETITIVE AND/OR FORCEFUL:

	NOT AT ALL	OCCASIONAL 0-33%	FREQUENT 34-66%	CONTINUOUS 67-100%
Gripping/grasping	☐	☐	☐	☐
Repetition wrist motion	☐	☐	☐	☐
Reaching:	☐	☐	☐	☐
Above shoulder height	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐
Below shoulder height	☐	☐	☐	☐
Restrictions (circle)	☐	☐	☐	☐

Keyboarding (hrs/shift) 0 1-2 3-4 5-6 7

Writing (hrs/shift) 0 1-2 3-4 5-6 7

Total spread out evenly over shift at _____ intervals

Change positions every

☐ As needed ☐ Half hour ☐ One hour ☐ Two hours

☐ Work site stretches, i.e., per handout

☐ Exercises ☐ Other _____

Comments _____

Prognosis: ☐ On schedule, full recovery expected by _____ ☐ Delayed recovery ☐ Full recovery not expected

INSTRUCTIONS

☐ Keep wound clean and dry. Change dressing every _____

☐ Medication _____

☐ Ice _____ min. _____ ☐ Heat _____ min. _____

☐ Splint / Brace _____

☐ Referral _____

RETURN TO CLINIC ON: _____

THIS TREATMENT PLAN HAS BEEN DISCUSSED WITH THE EMPLOYEE ☐ Yes ☐ No

HEALTH CARE PROVIDER SIGNATURE	LICENSE/REGIS.	DATE OF EXAM	EMPLOYEE SIGNATURE

NAME & ADDRESS OF HEALTH CARE FACILITY (print)	RELEASED TO WORK
	SIGNATURE DATE