Catholic Diocese of Sioux Falls

WORKERS' COMPENSATION CHECKLIST

FIRST AID/INCIDENT ONLY

EMPLOYEE NOT SEEKING TREATMENT

This checklist is for managers to use for employees who have had an incident/injury but the employee DOES NOT REQUIRE OR WANT TO SEEK outside medical treatment with a physician or medical provider. This is considered **FIRST AID/ONSITE TREATMENT ONLY**.

AFTER the scene of the accident has been secured:

☐ **Complete the "Accident Investigation/Incident Report – First Aid only" form and send it to the Catholic Diocese of Sioux Falls Human Resources office.** Make sure this form is signed and dated by the employee. This document must be completed in detail. The person reading it should be able to tell exactly how and what happened. *If you have questions, please call or email Renee Leach at 605-988-3752 / rleach@sfcatholic.org or Twila Roman at 605-988-3741 / troman@sfcatholic.org)*

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 and **TAKE PICTURES** of the accident scene as soon as you can after the injury has occurred if possible.
D. Note if the injury was due to a faulty/damaged tool, object, etc. and if so keep that item as it could be considered evidence if the incident develops into a claim.
E. Provide a **Witness Statement Form** to all potential witnesses to the injury claim and follow up to assure all completed statements from all potential witnesses are obtained. Make sure you obtain all their contact information if they are not your employees!
F. **DO NOT** investigate from your "desk."

☐ Please be sure to advise and point out to the employee (as is stated at the bottom of the Incident Only/First Aid form) **that if they wish to seek treatment at a later date as it pertains to this incident, they must IMMEDIATELY notify you, at which time the "Seeking Treatment" process will begin and a First Report of Injury will be completed/filed with the Work Comp Insurance Carrier and/or WC Agent.**

☐ **Follow-up with the employee on a weekly basis asking "How they are doing/feeling" etc.** If/When the employee states he/she is at "Pre-Injury" status and feels he/she has fully recovered from their "incident/injury," **have him/her sign off on the "Pre-Injury Status" form and attach it to the Incident/Notice Only form and file away. Hold onto this documentation for 4 years**.

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

Incident Report / No Treatment Sought – Catholic Diocese of Sioux Falls

This form must be completed each time an injury or accident occurs in which the employee states he/she was injured, but at the time of reporting, does not feel medical treatment is needed or indicated. **This must be turned in to the Catholic Diocese HR Department w/in 24 hours of being reported**. **If the injured employee at any time thereafter, and wherein related to the reported injury, feels he/she requires medical treatment as a result of the work incident, a SD First Report of Injury MUST BE completed** and this Incident Report attached and submitted to the insurer for reporting to the State.

Part I - Employee Information

Employee Name	Department	Shift

Part II - Accident Data

Date of Incident or Injury:	Time ☐ am ☐ pm	At this time does not require medical treatment? ☐ ck if you agree.	Who was the supervisor/manager this was reported to?_____	Witnesses? Please list names.

List the **BUILDING AREA** where the incident happened:

List the **NATURE** of the injury (example – burn, sprain, cut, etc.):

Tell what **HAPPENED** (include job(s), part name, equipment, tools or products that were involved)

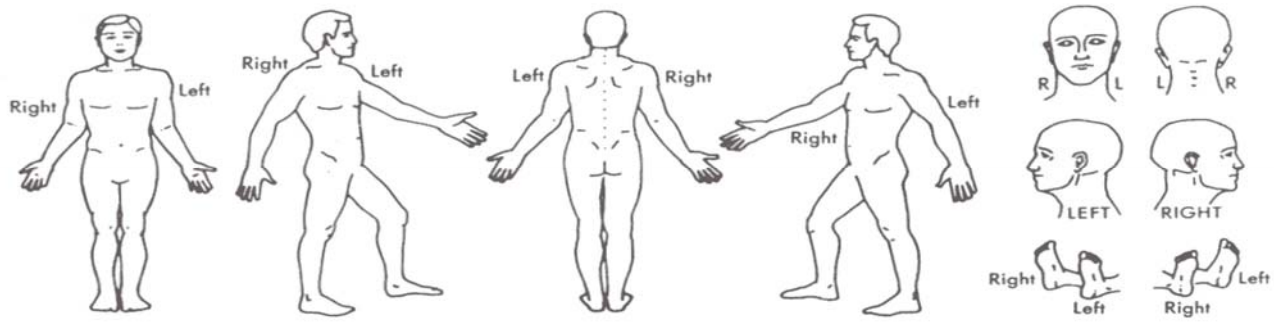
(If this injury has occurred over a duration of time – list the jobs you have been doing and for how long)

Did the incident or injury involve any other personnel? Yes No If yes, please describe:

What would **PREVENT** this type of incident from happening again?

Part III - Location of discomfort/pain

1. List all Body Parts that are injured or hurting (example – right wrist, lower back, left arm): _____
2. Please circle or mark on the drawing the location of your pain.



Part IV - Description of Pain.

Please check all that apply. If none of these words describe the pain correctly, please use your own words in the comment section.

☐ Sharp ☐ Ache ☐ Dull ☐ Burning ☐ Tingling ☐ Prick ☐ Pull ☐Pressure ☐ Stiffness ☐ Shooting
☐ Numbness☐ Shooting ☐ Constant ☐ Throb ☐ Positional ☐ Weakness ☐ Cramping ☐ Intermittent

COMMENTS:

Part V - Intensity of Pain

Please rate the pain on a scale of one to ten with ten being the highest.

Rate your pain RIGHT NOW.	No pain	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Worst Pain
Rate your pain at its WORST.	No pain	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Worst Pain
Rate your pain at its BEST.	No pain	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Worst Pain

Part VI - Onset/Duration of Pain

A. When did you first notice the pain?

B. What makes the pain better? C. What makes the pain worse?

D. Are there any other effects of the pain? For example: difficulty sleeping, becoming nauseated, difficulty doing ordinary tasks. Please describe.

Only complete this form if you feel the injury or symptoms are work-related in nature. You must complete this form with your supervisor – (or backup supervisory personnel). This completed form will be placed in your confidential medical files and with any applicable worker's compensation files required by OSHA. **BY SIGNING THIS FORM, YOU ARE ALSO STATING THAT YOU DO NOT FEEL YOU REQUIRE MEDICAL TREATMENT AT THIS TIME, BUT ARE MERELY REPORTING A WORK RELATED INCIDENT. If you require treatment at a later date, you must IMMEDIATELY notify your supervisor/manager and a SD First Report of Injury will be completed**

EMPLOYEE SIGNATURE: **DATE:**

Signature of Supervisor completing report w/ employee: **DATE:**

Supervisor's Incident Report

Every incident or accident should be investigated and the causes corrected so that more accidents will not occur. Do not overlook the so-called "unimportant" cases, because, except for "chance" they could also have been serious. It is only by thorough investigation that many of the real causes can be determined and corrected.

Part I- Accident Description

Date of Incident or Injury	Date reported to employer:	Witness(es)
Describe incident in detail. Include what and how it happened, why and where,		

Part II- Medical Exposure Control Information: Please check here if there was no exposure ☐

Source Person		Exposed Person (s)/Title/Dept
Area of body involved for exposed person	Route of entry	Exposed Person (s)/ Dept/Title
Was personal protective equipment used? ☐ yes ☐ no	If so, what types:	
Comments:		

Part III: Please give your honest comments on the questions below. Your opinion may help us prevent accident repetition.

1. Was proper instruction given to the employee on how to do the job safely and efficiently?	1. Yes No Not Applicable
2. Did injured person violate any instructions?	2. Yes No Not Applicable
3. Did the employee wear the proper personal protective equipment when this job was being done?	3. Yes No Not Applicable
4. Was the work area clean and well organized? (i.e parts on floor, aisles obstructed , wet floor etc.) Did poor housekeeping contribute to injury?	4. Yes No Not Applicable
5. Did horseplay contribute towards the cause of the injury?	5. Yes No Not Applicable
6. Was there equipment involved that needed repairs? (i.e. broken ladder, oil leak, bad electric cord)	6. Yes No Not Applicable
7. Would a guard prevent another incident from happening? (i.e. guard around belts and pulleys, railing properly in place, etc.)	7. Yes No Not Applicable
8. Did this person have any physical limitations which might have contributed towards the accident? (i.e. poor vision, previous injury etc.)	8. Yes No Not Applicable
9. Did the employee report the injury to you, the supervisor, immediately?	9. Yes No Not Applicable

Part IV – Incident Analysis: Circle ALL the factors that prevented "Problem-free Performance" & may have contributed towards the cause of this incident:

PROCESS ORGANIZATION FACTORS	PROCESS CONTROL FACTORS	HUMAN FACTORS
Excessive force required to do the job.	Person not trained to do job safely.	Did not understand safety procedures
Too much weight has to be lifted or moved.	Not enough people available for job.	Did not follow safety procedures (tools, equipment usage,
Awkward hand or arm positions required.	Not enough job rotation	speeds of operation, or material usage)
Excessive reaching, leaning, bending required	Safe work practices were not adequate.	Did not report hazardous conditions or secure
Tools provided were not suitable for job.	Safe work practices were not monitored	Did not correct hazardous conditions
Safe work practices were not written	Damaged tools or equipment used.	Physical limitations interfered with performance.
Some safety hazards were overlooked in the process design	Tools or equipment out of adjustment	Operating without authority
Work area was too small for the process	Tool or equipment not available	Failure to use equipment provided (incl. PPE)
Lighting was inadequate	Preventative maintenance not performed	Making safety devices inoperative
	Part or materials were defective	Lack of knowledge or skill
List other organization factors below:	Parts or materials were wrong for the job.	
	List other control factors below:	List other human factors below:
Describe any unsafe conditions:		

Part V - Corrective Action Taken

What have you done or what do you recommend to prevent recurrences of a similar accident?	Who will do it?	Due Date:	Date of Completion

Have corrections been made? ☐ yes ☐ no	If not, please give reason:	Did you review ways to prevent recurrences with the injured employee? ☐ yes ☐ no
Action Taken to Prevent Recurrence:		**"Safety Alert" or other form of posted communication of CAR:** ☐

INITIAL REPORT:

Immediate Supervisor Date	**APPROVAL – This section should only be completed after approval & confirmation of completed corr. action** Plant Manager Approval and Completion Date	HR Coordinator Approval & Completion Date ☐ CC; HR Dir. ☐ Database Input

Safety Coordinator Use Only ☐ List on wkly staff report ☐ CC: Plant Mgr. ☐ Schedule for nurse ☐ S.Comm ☐ Employee Follow up ☐ FROI (if applic.) ☐ OSHA Log ☐ Database Input

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

INCIDENT ONLY / NO TREATMENT SOUGHT
PRE-INJURY STATUS
SIGN OFF BY EMPLOYEE

Date: _____

RE: INCIDENT REPORT / NO TREATMENT SOUGHT

I _____ have made a full recovery and am at
(Name of Employee – Printed)

"Pre-Injury Condition/Status" from the injury I incurred on

_____ to my _____ of which I did not seek
(date) *(body part(s))*

medical treatment.

Employee Name *(Printed)* _____

Employee Signature _____

Supervisor Name *(Printed)* _____

Supervisor Signature _____