



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

Accident Investigation Report / 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, and wishes to seek medical Treatment. This must be turned in Catholic Diocese of Sioux Falls HR Department within 24 hours of being reported. A SD First Report of Injury MUST be completed along with this Accident Investigation Report and should be attached and submitted to the insurer along with the First Report of Injury for reporting to the State.

Part I - Employee Information

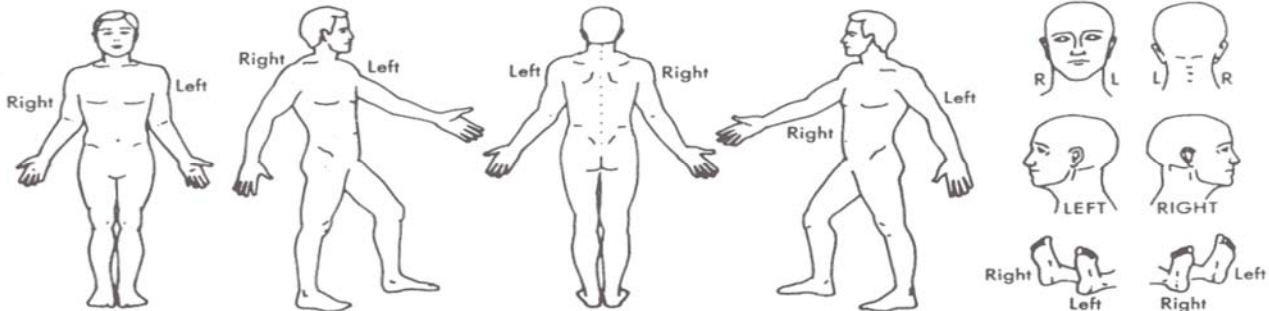
Employee Name	Department	Shift
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Part II - Accident Data

Date of Incident or Injury:	Time <input type="checkbox"/> am <input type="checkbox"/> pm	At this time does not require medical treatment? <input type="checkbox"/> 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.									
<input type="checkbox"/> Sharp	<input type="checkbox"/> Ache	<input type="checkbox"/> Dull	<input type="checkbox"/> Burning	<input type="checkbox"/> Tingling	<input type="checkbox"/> Prick	<input type="checkbox"/> Pull	<input type="checkbox"/> Pressure	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Shooting
<input type="checkbox"/> Numbness	<input type="checkbox"/> Shooting	<input type="checkbox"/> Constant	<input type="checkbox"/> Throb	<input type="checkbox"/> Positional	<input type="checkbox"/> Weakness	<input type="checkbox"/> Cramping	<input type="checkbox"/> 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.

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? <input type="checkbox"/> yes <input type="checkbox"/> 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.

<ol style="list-style-type: none"> 1. Was proper instruction given to the employee on how to do the job safely and efficiently ? 2. Did injured person violate any instructions? 3. Did the employee wear the proper personal protective equipment when this job was being done? 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? 5. Did horseplay contribute towards the cause of the injury? 6. Was there equipment involved that needed repairs? (i.e. broken ladder, oil leak, bad electric cord) 7. Would a guard prevent another incident from happening? (i.e. guard around belts and pulleys, railing properly in place, etc.) 8. Did this person have any physical limitations which might have contributed towards the accident? (i.e. poor vision, previous injury etc.) 9. Did the employee report the injury to you, the supervisor, immediately? 	<table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 10%;">1. Yes</td><td style="width: 10%;">No</td><td style="width: 80%;">Not Applicable</td></tr> <tr><td>2. Yes</td><td>No</td><td>Not Applicable</td></tr> <tr><td>3. Yes</td><td>No</td><td>Not Applicable</td></tr> <tr><td>4. Yes</td><td>No</td><td>Not Applicable</td></tr> <tr><td>5. Yes</td><td>No</td><td>Not Applicable</td></tr> <tr><td>6. Yes</td><td>No</td><td>Not Applicable</td></tr> <tr><td>7. Yes</td><td>No</td><td>Not Applicable</td></tr> <tr><td>8. Yes</td><td>No</td><td>Not Applicable</td></tr> <tr><td>9. Yes</td><td>No</td><td>Not Applicable</td></tr> </table>	1. Yes	No	Not Applicable	2. Yes	No	Not Applicable	3. Yes	No	Not Applicable	4. Yes	No	Not Applicable	5. Yes	No	Not Applicable	6. Yes	No	Not Applicable	7. Yes	No	Not Applicable	8. Yes	No	Not Applicable	9. Yes	No	Not Applicable
1. Yes	No	Not Applicable																										
2. Yes	No	Not Applicable																										
3. Yes	No	Not Applicable																										
4. Yes	No	Not Applicable																										
5. Yes	No	Not Applicable																										
6. Yes	No	Not Applicable																										
7. Yes	No	Not Applicable																										
8. Yes	No	Not Applicable																										
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. Too much weight has to be lifted or moved. Awkward hand or arm positions required. Excessive reaching, leaning, bending required Tools provided were not suitable for job. Safe work practices were not written Some safety hazards were overlooked in the process design Work area was too small for the process Lighting was inadequate List other organization factors below:	Person not trained to do job safely. Not enough people available for job. Not enough job rotation Safe work practices were not adequate. Safe work practices were not monitored Damaged tools or equipment used. Tools or equipment out of adjustment Tool or equipment not available Preventative maintenance not performed Part or materials were defective Parts or materials were wrong for the job. List other control factors below:	Did not understand safety procedures Did not follow safety procedures (tools, equipment usage, speeds of operation, or material usage) Did not report hazardous conditions or secure Did not correct hazardous conditions Physical limitations interfered with performance. Operating without authority Failure to use equipment provided (incl. PPE) Making safety devices inoperative Lack of knowledge or skill 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? <input type="checkbox"/> yes <input type="checkbox"/> no	If not, please give reason:		Did you review ways to prevent recurrences with the injured employee? <input type="checkbox"/> yes <input type="checkbox"/> no
Action Taken to Prevent Recurrence:			“Safety Alert” or other form of posted communication of CAR: <input type="checkbox"/>

INITIAL REPORT:

Immediate Supervisor	Plant Manager Approval and Completion	HR Coordinator Approval & Completion
Date	Date	Date
<input type="checkbox"/> CC; HR Dir. <input type="checkbox"/> Database Input		
Safety Coordinator Use Only <input type="checkbox"/> List on wkly staff report <input type="checkbox"/> CC: Plant Mgr. <input type="checkbox"/> Schedule for nurse <input type="checkbox"/> S.Comm <input type="checkbox"/> Employee Follow up <input type="checkbox"/> FROI (if applic.) <input type="checkbox"/> OSHA Log <input type="checkbox"/> Database Input		

APPROVAL – This section should only be completed after approval & confirmation of completed corr. action

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

E M P L O Y E E	SSN: _____ Date of Birth: _____ Gender: M <input type="radio"/> F <input type="radio"/> Dependents: _____ Name: (Last) _____ (First) _____ (Middle initial) _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Telephone No.: _____ Employee signature: (X) _____ Date _____		Education: <input type="checkbox"/> Less than High School <input type="checkbox"/> GED or High School <input type="checkbox"/> Beyond High School	
	I N J U R Y / T R E A T M E N T	Date of Injury: _____ Time of Injury: _____ a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Fatality Date (if applicable): _____ County Where Injury Occurred: _____ Was Safety Equipment Provided? Yes <input type="checkbox"/> or No <input type="checkbox"/> Time Work Day Began on Date of Injury: _____ a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Was Safety Equipment Used? Yes <input type="checkbox"/> or No <input type="checkbox"/> Date Returned to Work (if applicable): _____ Did Injury Occur on Employer Premises? Yes <input type="checkbox"/> or No <input type="checkbox"/> Address or Location of Injury: _____ Description of Injury: _____ _____ Date Employer Notified of Injury: _____ Injury Reported to: _____ Witness: _____		(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 _____
Type of Treatment (please check one) <input type="checkbox"/> No Treatment <input type="checkbox"/> On-Site Treatment <input type="checkbox"/> Clinic <input type="checkbox"/> Emergency Room <input type="checkbox"/> 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: <input type="checkbox"/> Regular or <input type="checkbox"/> Temporary Emp. Status: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer Date Employee Hired: _____ Employee's Position: _____ Employee's Time in Current Position: _____ Employee's Hours Per Week: _____ Employee's Current Wage: _____ \$ _____ per _____		
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; vertical-align:top;"> CLAIM OFFICE INFORMATION NAICS for Employer Being Insured (Nature of Business): _____ Carrier Code _____ FEIN (Claim Office) _____ Claim Office <u>Accident Fund Insurance Company of America</u> Claim Office Address <u>PO Box 40790</u> City <u>Lansing</u> State <u>MI</u> Zip Code <u>48901-7990</u> Telephone <u>866-206-5851</u> Email Address _____ Claim Office Claim # _____ Date Notified _____ Date to DOL _____ </td> <td style="width:50%; vertical-align:top;"> <input checked="" type="checkbox"/> 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 <u>WCV6130319</u> Effective Dates <u>7/1 Policy Year</u> Adjuster/Contact Person _____ </td> </tr> </table>			CLAIM OFFICE INFORMATION NAICS for Employer Being Insured (Nature of Business): _____ Carrier Code _____ FEIN (Claim Office) _____ Claim Office <u>Accident Fund Insurance Company of America</u> Claim Office Address <u>PO Box 40790</u> City <u>Lansing</u> State <u>MI</u> Zip Code <u>48901-7990</u> Telephone <u>866-206-5851</u> Email Address _____ Claim Office Claim # _____ Date Notified _____ Date to DOL _____	<input checked="" type="checkbox"/> 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 <u>WCV6130319</u> Effective Dates <u>7/1 Policy Year</u> Adjuster/Contact Person _____
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For information regarding the Workers' Compensation System please visit www.sdjobs.org



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: _____

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**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

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HIPAA 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

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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 / releach@sfcatholic.org or Twila Roman / troman@sfcatholic.org)

EMPLOYEE	SS #	SUPERVISOR	DEPARTMENT
JOB TITLE			DATE OF INJURY / ILLNESS

DIAGNOSIS	ICD-9 CODE
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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.
MO DAY YR MO DAY YR

Unable to work from ____ / ____ / ____ through ____ / ____ / ____
MO DAY YR MO DAY YR

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

EMPLOYEE'S CAPABILITIES	From: <input type="checkbox"/> PMD _____ Dated: _____	IME _____ Dated: _____
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BODY PART AFFECTED: Left Right Both Neck Upper Back Lower Back Shoulder Elbow
 Wrist Hand Leg Knee Ankle Foot Other _____

	HAND, WRIST AND SHOULDER ACTIVITIES AVOID PROLONGED, REPETITIVE AND/OR FORCEFUL:			
	NOT AT ALL	OCCA-SIONAL 0-33%	FRE-QUENT 34-66%	CON-TINUOUS 67-100%
Lift/Carry				
0-09 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10-19 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20-29 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30-39 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40-49 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No lift from floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/Pull without resistance:				
0-19 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20-40 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> 49 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist/turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel/squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand/walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ladder/stair climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gripping/grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repetition wrist motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching:				
Above shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Below shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restrictions (circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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				
<input type="checkbox"/> As needed		<input type="checkbox"/> Half hour		
<input type="checkbox"/> One hour		<input type="checkbox"/> Two hours		
<input type="checkbox"/> Work site stretches, i.e., per handout				
<input type="checkbox"/> Exercises <input type="checkbox"/> 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	DATE
		SIGNATURE	