

# WORK INJURY INSTRUCTIONS

If you have an injury at work, you must follow these steps:

- ❖ Report the injury to your supervisor immediately. Your supervisor will assess the injury and help you decide if you should go to Occupational Medicine and Wellness for treatment. Either your supervisor or Human Resources can call and make an appointment for you.
  - Take the Treatment/Progress Report with you to Occupational Health for completion.
  - Bring Treatment/Progress Report back to HR (or your supervisor if Human Resources is not available) immediately following your appointment.
  - If your injury requires a prescription please contact Human Resources before you pick up your prescription so that you can have the correct forms.
- ❖ Your supervisor will help you fill out the forms attached to this memo. Forms must be filled out **IMMEDIATELY** and **COMPLETELY** use as much detail as possible. Do not leave **ANY** blanks and please use good penmanship.
- ❖ **ALL** of the forms need to be completed within their shift and forwarded to Human Resources for processing.
  - Supervisors should return a **copy** of the Supervisor Incident Investigation Report with the other forms & return the original after completing the 24 to 72-hour contact portion.
- ❖ If your injury is any muscle related condition, you must contact the Rehab Department (ext. 239) at Western Home Communities within 1 week of the injury. You will need to set up an appointment to go over the injury that occurred.

**Monday through Friday (7:00 am to 5:30pm)**

Occupational Medicine at Arrowhead Medical Center

226 Bluebell Road Cedar Falls, IA

Phone: 575-5600

**After Hours**

Emergency Room at Sartori Memorial Hospital



# EMPLOYEE INCIDENT REPORT

(To be completed by the employee)

Facility name \_\_\_\_\_

Employee name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Job Title \_\_\_\_\_  
(CNA, LPN, ETC)

Address \_\_\_\_\_ Street, Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Hire Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_

Marital Status \_\_\_\_\_ # of Dependent children \_\_\_\_\_ # of other dependents \_\_\_\_\_

Date of incident \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of incident \_\_\_\_\_ AM  
PM Date Reported \_\_\_\_/\_\_\_\_/\_\_\_\_

Location of Incident \_\_\_\_\_  
(SHOWER ROOM, KITCHEN, HALLWAY, ETC.)

Scheduled hours: \_\_\_\_\_ Time work began: \_\_\_\_\_ AM  
PM Shift worked: 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup>

Describe the incident completely: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the injury or illness (be specific about body part (s) affected): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever injured this part of your body before? YES NO If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Did pain develop: suddenly \_\_\_\_\_ gradually \_\_\_\_\_ no pain \_\_\_\_\_

Do you plan to seek medical attention? YES NO If yes, you must see the designated physician.\*

Were you using safety equipment when the injury occurred:  
Gait belt YES NO N/A  
Lifting device YES NO N/A  
Other protective equipment \_\_\_\_\_

How could this injury have been prevented? \_\_\_\_\_  
\_\_\_\_\_

Who did you report this injury to? \_\_\_\_\_

Witness(es) \_\_\_\_\_

Name of supervisor: \_\_\_\_\_ Date Reported \_\_\_\_\_

By signing below, I attest to the truth of the information contained in this report, authorize the release of all medical information pertinent to this workers' compensation claim, and further authorize my employer to release my employment records. This release is signed at the request of my employer, CCMSI, and their representatives.

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

**INCIDENT REPORTS MUST BE GIVEN TO YOUR SUPERVISOR OR ACTING SUPERVISOR IMMEDIATELY AFTER ANY INCIDENT.**

\* Filing the appropriate paperwork does not guarantee payment under workers' compensation.

**AUTHORIZATION TO RELEASE INFORMATION  
REGARDING CLAIMANTS SEEKING WORKERS' COMPENSATION BENEFITS**

Name of Patient: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**SECTION I. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR REDISCLOSURE**

I authorize Covenant Health Systems  
to disclose and deliver to: Iowa Long Term Care Risk Mgmt Association  
the following information related to me: Any and all information EXCEPT substance abuse (drug or alcohol), mental health, and AIDS-related information, unless specifically authorized to be released in section II of this form.

**NOTE:** If the information includes mental health treatment, substance abuse treatment or HIV-related information it will not be released unless the undersigned patient agrees to the release on the reverse side of this form.

I understand the information is being disclosed and may be used only for legal and/or litigation purposes relating to claims and/or suit against Western Home Communities

I understand that this Authorization may be used to obtain information from health care providers, schools, former and current employers, providers of vocational rehabilitation services, the Social Security Administration, and the Iowa Department of Workforce Development. I understand that I have a right to inspect the disclosed information at any time. This authorization is effective until the conclusion of a contested case on the claim. I understand that I may revoke this Authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper. I also understand that if I revoke, the revocation will take effect on the day it is received in writing by the entity from whom disclosure is sought.

I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

Iowa and Federal law provide that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below. I understand that the Recipient of this Authorization, WITHOUT FURTHER AUTHORIZATION, may redisclose this information to:

- Parties and their legal counsel, insurers, experts, potential experts, but only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information;
- Agents, employees or representatives of the parties, but only after they are involved in conducting the prosecution or defense of the case, and only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information;
- Administrative agency and court officials hearing the claim, and their support staff.

**I SPECIFICALLY AUTHORIZE AND CONSENT TO ANY SAID DISCLOSURE AND REDISCLOSURE DESCRIBED ABOVE.**

\_\_\_\_\_  
Claimant or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship of Claimant's Legal Representative

**SECTION II. SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT OR AIDS-RELATED INFORMATION**

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Place "YES" or "NO" in ALL applicable boxes:]

Substance Abuse (Drug or Alcohol) information from all health care providers and facilities and any other person or entity in possession of records concerning me.

Mental Health information from all health care providers and facilities and any other person or entity in possession of records concerning me.

HIV or AIDS-related information, Diagnosis, and test results from all health care providers and facilities and any other person or entity in possession of records concerning me.

Furthermore, I SPECIFICALLY AUTHORIZE disclosure and re-disclosure of this confidential information to all of the persons referred to in the REDISCLOSURE Section I.

In order for the above information to be released you must sign here AND at the end of Section I

\_\_\_\_\_  
Signature of Claimant or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/ Zip Code

\_\_\_\_\_  
Printed Name and Relationship of Claimant's Legal Representative

Federal and/or State law specifically require that any disclosure or REDISCLOSURE of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

See also Chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.



# WORK INJURY INFORMATION

I understand the following:

- ❖ Occupational Medicine and Wellness will attempt to assist you to restore your health. *It is very important that you keep all scheduled appointments.*
  - *If you fail to report for a scheduled doctor's visit or physical therapy treatment it will be considered a "NO CALL/NO SHOW" and you may be disciplined up to and including termination.*
- ❖ If you choose to seek another physician's opinion, *it will be at your own expense.*
  - Western Home Communities, your private health insurance, and the workers' compensation insurance company *will not cover these costs.*
- ❖ After each visit to Occupational Medicine and Wellness, bring the progress report to Human Resources. Based upon your restrictions, if possible and/or necessary, a "Temporary Alternate Duty" work assignment will be given.
  - "Temporary Alternate Duty" forms are posted in your department so you will not be asked to work outside of your restrictions. *YOU are responsible for obeying your restrictions during recovery.*
- ❖ If you fail to report to work for your temporary alternate duty work assignment, you will not be paid for the day and you may be disciplined, up to and including termination.
  - Tardiness and absenteeism policies of Western Home Communities will be applied.
- ❖ Physical therapy/doctor appointments are to be scheduled during non-working hours as much as possible. Please the schedule with your Director/Supervisor.
- ❖ Back supports will be **required** for all employees who have had a back injury.
- ❖ Western Home Communities reserves the right to change your shift and duties as needed during your recovery time to accommodate your "Temporary Alternate Duty"

I have read the above information and understand its contents.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_



# TREATMENT PROGRESS REPORT

(To be completed by treating physician)

Employee \_\_\_\_\_ Injury Date \_\_\_\_\_

Employer Name \_\_\_\_\_

History of Injury \_\_\_\_\_

Diagnosis \_\_\_\_\_

### Work Status

- \_\_\_\_\_ Unable to perform any work activities
- \_\_\_\_\_ Fit for full duty on \_\_\_\_\_
- \_\_\_\_\_ Fit for modified duty on \_\_\_\_\_

### Work Restrictions

- \_\_\_\_\_ No lifting over \_\_\_\_\_ lbs.
- \_\_\_\_\_ Avoid repetitive bending or twisting
- \_\_\_\_\_ No overhead work
- \_\_\_\_\_ Sit down work only
- \_\_\_\_\_ Stand or walk limited to \_\_\_\_\_
- \_\_\_\_\_ No repetitive/forceful gripping, pinching, or wrist motion.
- \_\_\_\_\_ No overtime work
- \_\_\_\_\_ No kneeling or squatting
- \_\_\_\_\_ No pushing or pulling over \_\_\_\_\_ lbs.

Medications \_\_\_\_\_

Physical Therapy \_\_\_\_\_

Referral \_\_\_\_\_

To return to clinic on \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Discharged from care on \_\_\_\_\_

Physician Name \_\_\_\_\_ Date \_\_\_\_\_

Phone number \_\_\_\_\_

*Please call CCMSI at 1-800-982-2365 for authorization of referrals and diagnostic studies (MRI, CT, EMG, Bone Scan).*

**EMPLOYEE:** RETURN THIS FORM TO THE FACILITY IMMEDIATELEY AFTER DOCTOR VISIT.



# WITNESS INCIDENT REPORT

(To be completed by incident witness)

Injured employee's name \_\_\_\_\_

Date of incident \_\_\_\_/\_\_\_\_/\_\_\_\_

Time of incident \_\_\_\_\_ AM  
PM

Witness Name \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zip

Home Phone \_\_\_\_\_

Work phone \_\_\_\_\_

Job title of witness: \_\_\_\_\_

Location of Incident \_\_\_\_\_

(SHOWER ROOM, KITCHEN, HALLWAY, ETC.)

Did you actually see the incident?  YES  NO

Describe how the incident occurred based on what you saw or heard: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Describe the injury or illness in detail (be specific about body part (s) affected: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Has the employee made any comments regarding the incident? \_\_\_\_\_ If yes, what? \_\_\_\_\_

\_\_\_\_\_  
Are you aware of any pre-existing conditions to same body part? \_\_\_\_\_

\_\_\_\_\_  
Suggestions on how to prevent this incident from recurring: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Witness signature \_\_\_\_\_ Date: \_\_\_\_\_



# SUPERVISOR INVESTIGATION REPORT

(To be completed by the Supervisor)

Facility name \_\_\_\_\_

Employee's Name \_\_\_\_\_ Date of incident \_\_\_\_\_

Date Reported \_\_\_\_\_ Time Reported \_\_\_\_\_ AM  
PM

Injured Employee's Job Title \_\_\_\_\_ Department \_\_\_\_\_

Location of Incident \_\_\_\_\_  
(SHOWER ROOM, KITCHEN, HALLWAY, ETC.)

Time of Incident \_\_\_\_\_ AM  
PM Time Shift Began \_\_\_\_\_ AM  
PM

What was the employee doing at the time of the incident? (Be specific, equipment or materials being used) \_\_\_\_\_

Describe the injury or illness in detail (be specific about body part(s) affected) \_\_\_\_\_

Did the employee request medical treatment?  YES  NO

Was the employee directed to the designated doctor?  YES  NO

Name of treating physician \_\_\_\_\_

Is light duty available?  YES  NO # of days missed from work \_\_\_\_\_

Recommendation on how to prevent this incident from recurring \_\_\_\_\_

(Continue on the other side if necessary)

Was the employee following safety policies? \_\_\_\_\_

Was the employee wearing/using personal protective equipment? \_\_\_\_\_

Have you contacted the employee since this incident? \_\_\_\_\_

Name(s) of Witness (es) \_\_\_\_\_

Do you have any reason to believe this incident is not work related? \_\_\_\_\_

If yes, what? \_\_\_\_\_

What type of hobbies/activities is the employee involved in outside of work? \_\_\_\_\_

Signature of Supervisor \_\_\_\_\_

Phone Number \_\_\_\_\_ Date \_\_\_\_\_