Marathon County Worker’s Compensation Injury Or Illness Report Form

Procedures:

► An employee considering / requiring medical treatment must contact Nurse Triage Line at 844-891-6020 to assess injury and/or illness and provide helpful instructions plus need to complete this form. For all serious injury and/or illness, employee should seek immediate medical treatment and call Nurse Triage Line as soon as possible.

► In case of death or very serious accident, please immediately call Sharon Hernandez, Senior Human Resources Analyst at

715-261-1457 or Molly Adzic, Human Resources Director at 715-261-1406.

► Employee completes Section A within 2 days from date of injury / illness, if possible. If not, supervisor completes Section A.

► Supervisor completes Section B and sends completed form to Human Resources Department within 2 days from date of injury / illness and routes copy to department head, if required.

Section A — Completed By Employee, If Possible

|  |  |  |  |
| --- | --- | --- | --- |
| Employee’s Name | Click here to enter text. | Job Title | Click here to enter text. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Department | Click here to enter text. | Time Workday Began | Click here to enter text. | AM | PM |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Injury or Onset of Work-Related Illness | Click here to enter a date. | Time of Injury / Illness | Click here to enter text. | AM | PM |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Office Phone # | Click here to enter text. | Home Phone # | Click here to enter text. | Cell Phone # | Click here to enter text. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date & Time Reported Injury / Illness to Supervisor | Date | Click here to enter a date. | Time | Click here to enter text. | AM | PM |

|  |  |  |  |
| --- | --- | --- | --- |
| Supervisor Name | Click here to enter text. | Supervisor’s Work Phone # | Click here to enter text. |

If not reported to supervisor on day of injury / illness, why?

|  |
| --- |
| Click here to enter text. |

Specific location of injury / illness (examples; name of building and the exact location within building, main entrance steps located on the east side of Courthouse; property address, street address, include truck or vehicle #, etc.)

|  |
| --- |
| Click here to enter text. |

What were you doing just before the injury / illness occurred?

|  |
| --- |
| Click here to enter text. |

What happened / how did the injury or work-related illness occur?

|  |
| --- |
| Click here to enter text. |

What is the injury / illness? (Please be specific in your description of the injury / illness and identify the body part affected on the below chart)

|  |
| --- |
| Click here to enter text. |

Part of body injured (check ALL that apply, and check appropriate position) Thumb = Finger 1; Big Toe = Toe 1

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Abdomen |  | Eye R  L |  | Finger – 5th R  L |  | Hip R  L |  | Pelvis |  | Toe – 4th R  L |
|  | Ankle R  L |  | Elbow R  L |  | Foot R  L |  | Knee R  L |  | Ribs |  | Toe – 5th R  L |
|  | Arm R  L |  | Finger – 1st R  L  L L |  | Groin |  | Leg R  L |  | Shoulder R  L |  | Wrist R  L |
|  | Back - Upper |  | Finger – 2nd R  L |  | Hand R  L |  | Mouth |  | Toe – 1st R  L |  | |
|  | Back – Middle |  | Finger – 3rd R  L |  | Head |  | Neck |  | Toe – 2nd R  L |
|  | Back - Lower |  | Finger – 4th R  L |  | Heel R  L |  | Nose |  | Toe – 3rd R  L |
|  | Other – Please specify: Click here to enter text. | | | | | | | | | | |
| For hand and arm injuries, please check your dominant arm: Right  Left | | | | | | | | | | | |

Type of Injury / Illness

|  |  |  |  |
| --- | --- | --- | --- |
| Abrasion | Concussion | Gun Shot | Rash/Dermatitis |
| Amputation | Cut/Laceration | Infection | Respiratory |
| Bite | Exposure | Numbness | Strain / Sprain |
| Bruise / Contusion | Foreign Body | Pain | Whiplash |
| Burn | Fracture | Puncture |  |
| Other – Please list: Click here to enter text. | | | |

What object or substance (tools, machinery, objects, chemicals, etc.) directly harmed you? (Leave blank if this does not apply to the incident)

|  |
| --- |
| Click here to enter text. |

What protective devices/equipment were utilized or worn:

|  |
| --- |
| Click here to enter text. |

If operating equipment, machinery, and/or other motorizedequipment(s) lead to injury / illness, describe the equipment(s):

|  |
| --- |
| Click here to enter text. |

Was there any other safety equipment/resource available that could have been used to prevent this injury / illness?

Yes  No  Unknown

If yes, explain:

|  |
| --- |
| Click here to enter text. |

If physical handling was involved, describe the object/person being handled/lifted at time of the injury / illness:

|  |  |  |  |
| --- | --- | --- | --- |
| Approximate size | Click here to enter text. | Approximate weight | Click here to enter text. |
| Description | Click here to enter text. | | |

Explain the environmental factors (lighting, temperature, noise, vibration, dust or weather), if any, that you feel contributed to this injury / illness?

|  |
| --- |
| Click here to enter text. |

Were there witnesses? Yes  No  Unknown

If yes, witness name(s) and phone #(s):

|  |
| --- |
| Click here to enter text. |

Did anyone else contribute to this injury / illness? Yes  No  Unknown

If yes, please list name(s)

|  |
| --- |
| Click here to enter text. |

Did injury / illness involve outside third party? Yes  No  Unknown

(i.e. car accident, confrontation with inmate, etc.)

If yes, please list name(s) and phone number, if known:

|  |
| --- |
| Click here to enter text. |

Did you have any lost work time related to this injury / illness? Yes  No  Unknown

If yes, please complete:

|  |  |
| --- | --- |
| Last Day Worked | Click here to enter a date. |
| Date or Estimated Date of Return | Click here to enter a date. |

Did or will you seek professional medical treatment? Yes  No  Unknown

If yes, provide physician and clinic name(s):

|  |
| --- |
| Click here to enter text. |

First Aid only? Yes  No

Have you ever been treated for a similar injury (same part of body or condition)?

Yes  No  Unknown

If yes, when (approximate dates):

|  |
| --- |
| Click here to enter text. |

Names of Practitioner, Hospital or Clinic which provided prior treatment:

|  |
| --- |
| Click here to enter text. |

Other Comments:

|  |
| --- |
| Click here to enter text. |

***I certify that the above statements are true and accurate and I understand that a false worker’s compensation claim may result in disciplinary action up to and including termination of employment. Any person who makes or causes to be made any knowingly material misrepresentation for the purpose of obtaining Worker’s Compensation benefits or payment may be guilty of a crime.***

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Signature / Type Name | Click here to enter text. | Date | Click here to enter a date. |

|  |
| --- |
|  |

SECTION B — Completed By Supervisor

|  |  |
| --- | --- |
| Supervisor Name | Click here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| Did injury / illness cause death? | Yes  No | If yes, date of death | Click here to enter a date. |

|  |  |  |  |
| --- | --- | --- | --- |
| Have you received the employee statement? | Yes  No | Did you discuss the incident with the employee? | Yes  No |

Please describe what the employee was doing when the injury / illness occurred?

|  |
| --- |
| Click here to enter text. |

Did you observe the injury / illness? Yes  No

Please verify whether any witnesses where present or nearby.

Additional witnesses not included in employee’s response – name and phone #:

|  |
| --- |
| Click here to enter text. |

Did you talk to any witnesses? Yes  No

What did they say?

|  |
| --- |
| Click here to enter text. |

Do you agree with the employee’s account of the injury / illness? Yes  No

If no, explain:

|  |
| --- |
| Click here to enter text. |

Was the employee involved in an unsafe act? Yes  No  Unknown

If yes, explain:

|  |
| --- |
| Click here to enter text. |

Was any safety or work rules violated at the time of the injury? Yes  No  Unknown

If yes, explain:

|  |
| --- |
| Click here to enter text. |

If operating equipment, machinery, and/or other motorized equipment(s) lead to injury / illness, describe the equipment(s):

|  |
| --- |
| Click here to enter text. |

Was the equipment being properly used? Yes  No  Unknown

If no, please explain:

|  |
| --- |
| Click here to enter text. |

Was there any other equipment/resource available that could have been used to prevent this injury / illness?

Yes  No  Unknown

If yes, explain:

|  |
| --- |
| Click here to enter text. |

If physical handling was involved, describe the object/person being handled/lifted at time of the injury / illness:

|  |  |  |  |
| --- | --- | --- | --- |
| Approximate size | Click here to enter text. | Approximate weight | Click here to enter text. |
| Description | Click here to enter text. | | |

Explain the environmental factors (lighting, temperature, noise, vibration, dust or weather), if any, that you feel contributed to this injury / illness?

|  |
| --- |
| Click here to enter text. |

How would this type of injury / illness be prevented from happening again?

|  |
| --- |
| Click here to enter text. |

Is any follow-up needed? Yes  No  Unknown

If yes, explain:

|  |
| --- |
| Click here to enter text. |

What are the specific recommendations you would make in order to prevent this type of accident/injury from recurring?

|  |
| --- |
| Click here to enter text. |

Would the employee benefit from any type of training? Yes  No  Unknown

If yes, what type of training?

|  |
| --- |
| Click here to enter text. |

Action plan to prevent reoccurrence:

|  |
| --- |
| Click here to enter text. |

|  |  |
| --- | --- |
| Who has been assigned to complete follow-up, if needed? | Click here to enter text. |

|  |  |
| --- | --- |
| Anticipated completion date | Click here to enter a date. |

Additional Comments:

|  |
| --- |
| Click here to enter text. |

***I certify that the above statements are true and accurate and I understand that a false worker’s compensation claim may result in disciplinary action up to and including termination from employment.***

|  |  |  |  |
| --- | --- | --- | --- |
| Supervisor Signature / Type Name | Click here to enter text. | Date | Click here to enter a date. |
| Contact Phone # | Click here to enter text. | | |

Send Completed Form to Human Resources Department

Within 2 Days of Date of Injury & Route Copy to Department Head, If Required.