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		Job Title	

Department		Time Workday Began		☐AM	☐PM

Date of Injury or Onset of Work-Related Illness		Time of Injury / Illness		☐AM	☐PM

Office Phone #		Home Phone #		Cell Phone #	

Date & Time Reported Injury / Illness to Supervisor	Date		Time		☐AM	☐PM

Supervisor Name		Supervisor's Work Phone #	

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

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.)

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

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

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)

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 ☐	☐	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:										
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:			

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

What protective devices/equipment were utilized or worn:

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

Was there any other safety equipment/resource available that could have been used to prevent this injury / illness?
Yes ☐ No ☐ Unknown ☐

If yes, explain:

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

Approximate size		Approximate weight	
Description			

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

Were there witnesses? Yes ☐ No ☐ Unknown ☐
If yes, witness name(s) and phone #(s):

Did anyone else contribute to this injury / illness? Yes ☐ No ☐ Unknown ☐
If yes, please list name(s)

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:

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

If yes, please complete:

Last Day Worked	
Date or Estimated Date of Return	

Did or will you seek professional medical treatment? Yes ☐ No ☐ Unknown ☐
If yes, provide physician and clinic name(s):

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):

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

Other Comments:

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		Date	

SECTION B — Completed By Supervisor

Supervisor Name	

Did injury / illness cause death?	Yes ☐ No ☐	If yes, date of death	

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?

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 #:

Did you talk to any witnesses? Yes ☐ No ☐
What did they say?

Do you agree with the employee's account of the injury / illness? Yes ☐ No ☐
If no, explain:

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

If yes, explain:

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

If yes, explain:

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

Was the equipment being properly used? Yes ☐ No ☐ Unknown ☐

If no, please explain:

Was there any other equipment/resource available that could have been used to prevent this injury / illness?
Yes ☐ No ☐ Unknown ☐

If yes, explain:

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

Approximate size		Approximate weight	
Description			

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

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

Is any follow-up needed? Yes ☐ No ☐ Unknown ☐

If yes, explain:

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

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

If yes, what type of training?

Action plan to prevent reoccurrence:

Who has been assigned to complete follow-up, if needed?	

Anticipated completion date	

Additional Comments:

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		Date	
Contact Phone #			

Send Completed Form to Human Resources Department
Within 2 Days of Date of Injury & Route Copy to Department Head, If Required.