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Associate Incident Statement

Name:________________________________Associate ID: ________________________

Date of Incident: ______________________ Time of Incident: _______________ AM/PM

Location:____

Date Reported to Supervisor: ________________ Supervisor Name: ____________________

Please answer, in detail, the following questions (Use back of page if needed):

What happened? ____
____
____
____

How did it happen? ____
____
____
____
____

Witness(s)? (list names): ____
____

Describe the nature of your injury (include all body parts involved): _____________
____
____
____

What, if any, treatment was required?: ______________________________________
____
____

Where was treatment obtained?: ____
____
____

What corrective action(s) would you recommend to prevent recurrence? ________
____
____

Signature of Associate:___________________________________Date: ____________

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BWC Claim # ____________
OSHA Reference # __________
Date of Report: _____________

SUPERVISOR INCIDENT REPORT

Procedure: This form is to be completed for all incidents occurring on company property, or during any company activity that requires medical or dental attention to be administered. This report form is to be completed by the end of the shift the day of the incident by the associate's supervisor, the nurse, or other appropriate individual.

A. *General information. This section to be completed for all incidents.*

Name of Injured: ________________________ Incident Location: ________________

Job Title: ________________________ Associate ID Number: ________________

Address: ________________________ Telephone No.: __________ ☐ Employee

________________________ Building/Department: __________ ☐ Visitor

Date of Incident: ________________________ Time of Incident: ______A.M. _______ P.M.

Date and Time Reported to Supervisor: ________________________

B. *Type of Injury. This section to be completed for all incidents.*

☐ Abrasion
☐ Bruise
☐ Burn
☐ Concussion
☐ Cut
☐ Dislocation
☐ Strain/Sprain
☐ Laceration
☐ Other, specify: ________________
☐ Fracture
☐ Puncture

SUPERVISOR INCIDENT REPORT

C. *Written Narrative. This section to be completed for all incidents.*

Describe incident giving full details (continue on back if needed): ________________

____

____

____

____

Property Damage included: ________________________

D. *This section to be completed for associate incidents only.*

Grade/Title: ________________________ Return to work date: ________________

Was associate following work/safety requirements?	☐Yes	☐No	☐N/A
Did incident occur during normal course of work?	☐Yes	☐No	☐N/A
Is incident OSHA Reportable?	☐Yes	☐No	☐N/A

Over→

If so was incident logged on OSHA 300?	☐Yes	☐No	☐N/A
Was CareWorks contacted?	☐Yes	☐No	☐N/A
Is injured worker a candidate for transitional work program?	☐Yes	☐No	☐N/A
Witness Statement(s) Obtained?	☐Yes	☐No	☐N/A

List names of witnesses: ______________________________

How could this incident have been prevented? ______________________________

____

Actions taken to prevent reoccurrence: ______________________________

____

E. *First Aid given. This section to be completed for all incidents.*

First Aid Administered: ______________________________

____

F. *Further care. This section to be completed for all incidents.*

☐ None
☐ Transported by ambulance to: ______________________
☐ Transported by management to: ______________________
☐ Spouse/relative took home
☐ Saw personal physician/dentist
☐ Other, specify: ______________

G. *Additional Remarks. This section to be completed for all incidents.*

____

____

H. *30 day follow-up on incident corrective actions.*

____

____

____

Person reporting: ______________________ Date Reporting: ______________

Associate: ______________________ Supervisor/Manager: ______________

Send Copies To:

All Incidents: Workers' Compensation/Safety Process Coordinator (Original), Supervisor/Manager (1)

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Witness Incident Statement

Name:________________________________Employee ID: ________________

Date of Incident: ___________________ Time of incident: _____________ AM/PM

Location:____

Name of injured associate(s): ____

Please answer, in detail, the following questions (Use back of page if needed):

What happened as observed? ____

What did you actually **SEE**? ____

Describe the nature of the associates's injury as observed: _____________

What corrective action(s) would you recommend to prevent recurrence? _______

Signature of Witness:_____________________________________Date: ___________

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Incident Document Checklist/Action Items

- ☐ Did the Associate follow the Incident Reporting Policy? Incident number created
- ☐ Copy of First Report of Injury (FROI) in our file & sent to **MCO**
- ☐ Initial contact with MCO to alert them of the claim & verify the information has been entered in **BWC**
- ☐ MEDCO 14 on file (Return to work, restrictions, off work, healthcare providers' name, and address of healthcare facility). A new Medco 14 should be requested after the last one on file expires. **(Copy MCO)**
- ☐ Release to Full Duty on file (if not part of the MEDCO 14) **(Copy to MCO)**
- ☐ Healthcare provider notes which outline the injury or illness, treatment, discharge notes, prescriptions, prognosis, etc. **(Copy MCO)**
- ☐ Verification that drug test was performed
- ☐ Incident Investigation Report completed
- ☐ Corrective actions with primary person responsible & estimated completion date (track to completion)
- ☐ Coaching, counseling, or disciplinary action (put in Associate Relations folder, not here)
- ☐ Decision was made on certifying or rejecting the claim **(TPA if Rejected, MCO if Certified)**
- ☐ Initial contact with **TPA** if any of the following apply:
  - Associate will miss more than 7 calendar days of work
  - Company is considering rejecting the validity of the claim
  - The injured worker is not your employee
  - The injured worker hasn't been released to full duty
- ☐ Decision was made if MD work is available & sent copy of MD/FD job description to **MCO & TPA**
- ☐ A MD job offer was sent via certified mail as soon as the Associate is released to return to LD work
- ☐ Decision was made on paying Salary Continuation or having the BWC pay TT compensation
  - If paying Salary Continuation (IW will miss 8 or more days): Wage sheet filled out (wages needed for one year prior to date of injury) & sent to **BWC & TPA** (TT = Temporary Total)
  - If BWC will pay TT compensation (IW will miss 8 or more days): wages submitted to **BWC**
- ☐ Keeping the **MCO, TPA, & BWC** up-to-date on the progress
- ☐ Copies of any documents from **BWC, MCO, or TPA** and decisions on appeals
- ☐ Supporting documents such as witness statements & supervisor notes collected **(copy to TPA)**
- ☐ Contact with Associate, Supervisor, **MCO, TPA & BWC** (see Contact Sheet Log)
- ☐ OSHA Recordability determination (Medical Only, Restricted Activity, Lost Time)
- ☐ OSHA 300 log filled out and/or updated

THE BOLDING SIGNIFIES WHO TO CONTACT WITH QUESTIONS OR GIVE INFORMATION TO: MCO = Managed Care Organization, TPA = Third Party Administrator, MD = Modified Duty, FD = Full Duty, IW = Injured Worker

- ✓ It is critical that we have a complete history of treatment and dates from the beginning of the incident to the release to full duty.
- ✓ During initial contact with the MCO verify that the healthcare provider has entered the information to start the claim. If they have not, we must enter the information.
- ✓ We must follow the treatment plan outlined by the healthcare provider especially in regards to restrictions. If something is not clear then we contact the healthcare provider or MCO for clarification. If the healthcare provider returns the Associate to work then the Associate must return or obtain revised documents from the healthcare provider. They are administratively absent until they do so.
- ✓ Workers Compensation lost time is after 7 days away from work, but OSHA lost time is any day after the date of injury regardless of salary continuation.