MEDICAL TREATMENT – INJURY PACKET – INSURED PORTION

Insured _____ State _____

Insured Contact _____ Phone Number _____

Carrier _____ Policy _____

INJURY DETAILS

Employee Name _____

Employee SSN _____ Employee DOB _____

Type of Injury _____

Date of Injury _____

Date Insured Informed _____

CHECKLIST

☐ Ensure **Employee** paperwork is completed in full.

- ☐ WC Claim Questionnaire
- ☐ Injured Employee's Statement
- ☐ Authorization for Release of Employment and Medical Records
- ☐ Ensure **Client** paperwork is completed in full.
- ☐ Description of Employee's Job Duties **Injured Employee must also sign this form.**
- ☐ Witness Report of Injury/Incident **Must be completed by ALL witnesses.**
- ☐ Injury/Illness Investigation Report
- ☐ State Specific Forms/Panels where applicable
- ☐ Take a picture of the **Injured Employee's face (with panel in panel states)** and injury.

DO NOT SEND THE EMPLOYEE TO THE CLINIC WITHOUT THE COMPLETED MEDICAL AUTHORIZATION FORM (*included*)

☐ Scan and email the injured worker's post-hire medical questionnaire, Second Injury Fund form (if applicable), and all injury paperwork to **claimfirstreport@usadminclaims.com**

☐ Have Employee watch safety video if available.

Employee should be paid for a full shift for the day of injury.

INJURY/ILLNESS INVESTIGATION REPORT

Name of Injured	
Date of Injury	
Accident Site Address	

KEY FACTORS

PROTECTIVE EQUIPMENT			**INFLUENCING FACTORS**			
TYPE OF EQUIPMENT	CURRENTLY REQUIRED	RECOMMENDED	FACTOR	FACTOR IN INJURY	POSSIBLE FACTOR	NOT APPLICABLE
Hard Hat			Not work related/ prior injury indicated			
Bump Cap			Inadequate Training by Client			
Safety Glasses			Inadequate Supervision			
Respiratory Protection			Safety Rules not followed			
Nuisance Mask			Increased Production Level			
Ear Protection			PPE not used			
			Job assignment changed			
Back Belt						
			Proper tools not provided			
Gloves						
			Restricted work space			
Work Boots						
			Poor housekeeping			
Steel-Toe Boots			Machinery			
			Possible personnel issues			
Rubber-Soled Shoes						
			Violation of Drug/Alcohol Policy			
Waterproof Boots						
			Machine Guarding			
Other:			Horseplay			
			Injured worker initiated horseplay			
Other:						

INJURY/ILLNESS INVESTIGATION REPORT (Continued)

COMMENTS ON KEY FACTORS

Action Taken with Employee (Do Not say "Told to be more careful.")

Preventive Action Recommendations

Reaction of Client to Recommendations

Photo(s) Taken?

☐ YES ☐

NO Surveillance

Video?

☐ YES ☐ NO

Witness (es) Present?

☐ YES ☐ NO

Name (s)

Comments

WITNESS STATEMENT (Completed by witness to injured employee's accident/injury.)

Print your name:	Injured Worker's Name:
Address:	
City, State, Zip Code:	Phone:
Date of Injury:	Time of Injury:
Company Name:	Position with Company:
1. Did you see the accident occur? ☐ Yes ☐ No If No, please sign and return.	
2. Did you witness what the injured employee was doing when the injury occurred? ☐ Yes ☐ No	
If yes, please describe:	
3. Describe in your own words how the injury/accident occurred.	
4. Describe the injury/accident witnessed in detail. (part of body affected)	
5. Were you aware of any previous injury to this employee? ☐ Yes ☐ No	
If yes, please explain:	
6. Was the employee instructed to do the specific task he/she was doing when the accident occurred? ☐ Yes ☐ No	
7. Did you witness any training of the employee before the actual work began? ☐ Yes ☐ No	
If yes, by whom?	
8. What equipment was being used when the accident occurred?	
9. What do you feel could have been done to prevent the accident?	
10. Comments	

I, _____, certify the above statement is true and correct. _____
Signature

WORKERS' COMPENSATION INJURY PACKET – EMPLOYEE PORTION

PERSONAL DETAILS

Name _____ Social Security # _____ Date of Birth _____

Email Address _____ Phone Number _____

Home Address _____

ACCIDENT DETAILS

Date &Time of Accident _____ Date injury reported to Supervisor/Employer _____

Location of Accident _____

INJURY QUESTIONS

1. Were there any witnesses to the accident? **YES** **NO**
   - If yes, please provide their names _____
2. What parts of your body were affected? _____
3. Where are you experiencing pain or discomfort? _____
5. Have you had previous problems with the injured part of your body? **YES** **NO**
   - If yes, please explain _____
   - If yes, are you currently under related medical care? **YES** **NO**

SAFETY QUESTIONS

1. When you were hired, did you watch the Employer's safety video (if applicable)? **YES** **NO**
2. Did the Employer explain to you the requirements of the job? **YES** **NO**
3. Was safety equipment given to you? **YES** **NO**
4. Were you performing your regular/assigned work? **YES** **NO**

5. In your opinion, was there something that could have been done differently to prevent the incident?

_____

_____

6. In your opinion, what caused the injury?
   - Poor Housekeeping
   - Poor Training
   - Machine/Equipment Failure
   - Employer Fault
   - Employee Fault
   - Other or N/A _____

SIGNATURES

_____	_____	_____
Employee Name (Print)	Employee Signature	Date
_____	_____	_____
Insured Representative	Insured Representative Signature	Date

INJURED EMPLOYEE'S STATEMENT

Describe in your own words how the injury/accident occurred.

Were you instructed to do the specific task you were doing when the accident occurred? Yes No

If yes, by whom?

Were you trained to do the task before the actual work began? Yes No

If yes, by whom?

Please describe any safety hazards you observed.

I certify the above statements are true and correct.

Employee Name (Please Print)_____

Employee Signature _____ Date _____

Insured Representative _____ Date _____
(Please print)

Insured Representative Signature _____

POST INCIDENT EMPLOYEE ACKNOWLEDGMENT

**** SEND WITH INJURED WORKER TO CLINIC ****

I, _____, understand that I will be drug/alcohol screened by the treating clinic. Failure to be screened within 8 hours (from initial notice of injury) will be considered a terminable offense.

I also understand that I must return all work status and/or doctor's reports to my Employer Representative immediately after being released from the medical facility and if/when released to work with or without restrictions, work will be available to me. Failure to report for light duty may affect workers' compensation benefits.

Employee Name _____ Employee Signature _____
(Please print)

Current Job Title: _____ Date of Hire _____

Date of Accident _____ Today's Date _____

Body part(s) to be treated: _____

Client Representative _____ Phone _____

This form does not guarantee benefits or payment. A copy of this form must be given to the Medical Provider (MPN in CA).

NOTE TO MEDICAL PROVIDER

- When permitted and ordered a rapid (if available) 9 or 10 panel drug screen is **required** with MRO confirmation of non-negative results.
- Submit all drug/alcohol screen results and work status updates directly to US Administrator Claims, LLC either by email at wc@usadminclaims.com or via fax at (866) 986-0118.
- All treatment billing for Workers' Compensation Claims will be coordinated with our TPA.

DESCRIPTION OF EMPLOYEE'S JOB DUTIES

** TO BE COMPLETED BY INSURED WITH EMPLOYEE **

INSTRUCTIONS: This form shall be completed jointly by the Client and employee and is intended to describe the employee's job duties. The completed form will be reviewed by the treating doctor to determine whether the employee is able to return to his/her job. This is an important document and should accurately show the requirements of the employee's job.

Employee Name Last: First: M.I.:		
Employer Name:	**Job Address:**	
Job Title:	Hours Worked Per Day:	Hours Worked Per Week:
DESCRIPTION OF JOB RESPONSIBILITIES: (Describe All Job Duties)		

I. Check the frequency of activity required of the employee to perform the job.

Activity (Hours per day)	Never (0 hours)	Occasionally (up to 3hours)	Frequently (3-6 hours)	Constantly (6-8+ hours)
Sitting				
Walking				
Standing				
Bending (Neck)				
Bending (Waist)				
Squatting				
Climbing				
Kneeling				
Crawling				
Twisting (Neck)				
Twisting (Waist)				
Hand Use: Dominant Hand **RIGHT** or **LEFT**				
Is repetitive use of hand required?				
Simple Grasping (Right hand)				
Simple Grasping (Left hand)				
Power Grasping (Right hand)				
Power Grasping (Left hand)				
Fine Manipulation (Right hand)				
Fine Manipulation (Left hand)				
Pushing & Pulling (Right hand)				
Pushing & Pulling (Left hand)				
Reaching (above shoulder level)				
Reaching (below shoulder level)				

II. Please indicate the daily lifting and carrying requirements of the job. Indicate the height the object is lifted from floor, table or overhead location and the distance the object is carried.				
LIFTING	**Height**	**Occasionally (up to 3hours)**	**Frequently (3-6 hours)**	**Constantly (6-8+ hours)**
0-10 lbs.				
11-25 lbs.				
26-50 lbs.				
51-75 lbs.				
76-100 lb.				
100+ lbs.				
CARRYING	**Distance**	**Occasionally (up to 3hours)**	**Frequently (3-6 hours)**	**Constantly (6-8+ hours)**
0-10 lbs.				
11-25 lbs.				
26-50 lbs.				
51-75 lbs.				
76-100 lb.				
100+ lbs.				

Is Buddy Lifting used on items carried/lifted weighing 50 pounds or more? Yes No

Describe the heaviest item required to carry and the distance to be carried:

_____

III. Please indicate if your job requires any of the following:			
TASK	**YES**	**NO**	**If YES, briefly describe**
Driving cars, trucks, forklifts and other equipment			
Working around equipment and machinery			
Walking on uneven ground			
Exposure to excessive noise			
Exposures to extremes in temperature, humidity or			
Exposure to dust, gas, fumes or chemicals			
Working at heights			
Operations of foot controls or repetitive foot movement			
Use of special visual or auditory protective equipment			
Working with bio-hazards such as: blood borne pathogens, sewage, hospital waste, etc.			

Employee Comments

_____

Insured Representative Comments

_____

Insured Representative Signature:	Date:
Employee Signature:	Date:

AUTHORIZATION FOR RELEASE OF EMPLOYMENT AND MEDICAL RECORDS

RE: _____(Employee Name)

Social Security Number _____

Date of Birth _____

Provider Name _____

Address _____

_____

Phone Number _____

To Whom It May Concern:

Permission is hereby given to furnish and release to **US Administrator Claims, LLC** or any representative thereof the following information:

1. All medical records pertaining to the examinations, treatments or consultations including but not limited to: billing records; x-rays, MRIs and diagnostic testing including reports; history records; diagnosis and prognosis records; nurses' and doctors' notes and all reports; and any psychiatric or mental health records; and all reports relating to diagnosis, care and treatment for drug and alcohol abuse.

2. All employment records pertaining to employment with your company, including but not limited to, personnel records, payroll records, medical records and time records.

3. I have the right to revoke this authorization at any time by writing to the healthcare provider listed above. Understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I understand that the information obtained will be used by The Carrier, Employer, and Third-Party Administrator, or any representative thereof, for the evaluation and processing of any claim(s) for workers' compensation benefits as a result of any claimed work-related injuries. I do not give permission for any other use or re-disclosure of this information.

This Authorization is valid until my claim has be accepted or denied, but in no event beyond one year from the date of my claimed injury. A photocopy of this Authorization is effective as the original.

I understand that I am entitled to a copy of this Authorization.

Employee Name _____ Employee Signature _____
(Please print)

Date _____

Modified Duty Policy

Employee Name | *Client* | *Location* | *Position Offered*

Date Modified Duty Offered | *Date Modified Duty Begins* | *Date of Assignment*

Hourly Pay Rate | *Total Weekly Hours* | *Shift Start Time* | *Shift End Time*

Description of duties: _____

_____

1. It is preferred that all modified duty employees schedule their therapy and doctors' visits around their scheduled work shift when possible.
2. No light duty employees are to be paid for time at therapy, doctor visits or time NOT worked, except where allowed by law.
3. All light duty employees are required to abide by the following guidelines while performing work at client offices and sites:
   → Remain in designated work area and perform all functions assigned by client and within doctor's restrictions.
   → Do not interfere, interrupt or disturb the operations of the client site and their staff.
   → Use of cell phones or computers while assigned to the client site is not permitted unless required by the assignment.
   → Light Duty employees are to have NO access to confidential information and are not to perform tasks which are normally performed by client employees.
4. It is the responsibility of the modified duty employee to schedule or provide their own transportation to home and the assigned work location. Mileage reimbursement where applicable by law will be provided for transportation to doctor and therapy visits.
5. It is the responsibility of the modified duty employee to keep track of their timesheet and have time verified, signed and turned into client.
6. All modified duty employees are expected to adhere to their assigned shifts and unapproved/unexcused tardiness or absences will be managed via the company standard disciplinary policies. Approved excused include:
   → Doctors' appointments (A note must be provided).
   → Sickness (if over 2 days, doctor's note must be provided to return to modified duty).
   → Pre-approved absences or tardies (must be pre-approved)
7. The company and client will abide by the terms of restrictions set forth by injured employee's treating doctors and expect that they will do the same at work and elsewhere.

I, _____, acknowledge I have received and understand the conditions set above in the company Modified Duty Policy. I also understand that the position being offered is a temporary position and is being offered to continue employment while I am recovering from this injury.

Please check <u>ONE</u>:

○ I ACCEPT this position being offered. ○ I DECLINE this position being offered.

Employee Signature | *Date* | *Insured Representative* | *Date*

Injured Employee Status Update Log

This form is to be completed daily for the duration of modified duty. Please email WC@invopeo.com each Monday with a copy of the employee's timecard.

_____ _____ _____ _____

Employee Name *Client* *Date of Injury* *Week Ending*

Ask employee daily how he/she is feeling on a scale of 1 (no pain) — 10 (extreme pain). Indicate in Notes section any concerns voiced by the employee and absences (full or partial day) including reason.

Date (MM/DD/YY)	Content with Modified Duty?	Notes	**Pain Scale (1 to 10)**	Hours Worked	Client Rep Initials	Employee Initials
_____	○ Yes ○ No		_____	_____	_____	_____
_____	○ Yes ○ No		_____	_____	_____	_____
_____	○ Yes ○ No		_____	_____	_____	_____
_____	○ Yes ○ No		_____	_____	_____	_____
_____	○ Yes ○ No		_____	_____	_____	_____
_____	○ Yes ○ No		_____	_____	_____	_____
_____	○ Yes ○ No		_____	_____	_____	_____