Injury Reporting

PACKET

HOCKING
COLLEGE

HOCKING COLLEGE SAFETY POLICY

It is the policy of Hocking College to provide a safe environment for all employees, students and visitors; and to promote continuing vital SAFETY AWARENESS.

Hocking College recognizes its responsibility to furnish an environment which shall be safe for all; to provide safety devices and mechanical safeguards to promote the use of methods and processes to protect the life, health, safety and welfare of employees, students, and visitors; and to maintain and enforce a program to fulfill this responsibility.

Therefore, it shall be each employee's responsibility not only to assure his or her personal safety, but to develop a concern for the safety of all College constituents.

The acceptance of employment at Hocking College obligates a person to follow the safety policies and procedures established by the College.

Any unsafe or hazardous action(s) knowingly performed by a College employee is/are subject to a disciplinary process.

Hocking College has established an Employee Safety Program to provide safe working conditions for all its employees. The program shall promote this goal by stressing safety awareness, employee education, periodic facility inspections, evaluations of work practices and accident review. Guidelines for the Employee Safety Programs are contained in the Hocking College Employee Safety Manual and the Hocking College Bloodborne Pathogen Compliance Manual.

Hocking College
Injury On The Job Claim Procedures

EMPLOYER AND BWC POLICY #:		YOUR WC COORDDINATOR:	
Name:	Hocking Technical College	**Name:**	Sheree Cunningham
Address:	3301 Hocking Parkway	**Title:**	Human Resources
City/State/Zip:	Nelsonville, OH 45764	**Phone:**	740-753-7040
BWC Policy #:	30007021		

IF YOU EXPERIENCE AN "ON THE JOB INJURY"

- Report the injury/incident to your supervisor and complete all necessary paperwork within twenty-four (24) hours of the injury/incident. Your supervisor will give you additional instructions as needed
- Give the Managed Care Organization (MCO) information (listed below) to the medical provider to ensure all bills and necessary documents are sent to the correct address
- Notify your supervisor/employer of your medical condition and keep your employer informed of the status of your injury

SEE YOUR SUPERVISOR OR WC COORDINATOR FOR ALL NECESSARY FORMS

MANAGED CARE ORGANIZATION:

CompManagement Health Systems, Inc.

PO Box 1040
Dublin, Ohio 43017
On-Line Reporting: www.chsmco.com

Fax: 1-800-334-4229
Customer Service: 1-888-247-7799
Injury Reporting: 1-888-247-4800

Hocking College Accident / Health Incident Report

(Please complete all sections and send all copies to *Human Resources* within 24 hours of the accident. Copies of this report may be sent to the person's Direct Supervisor, the Department Director, the Campus Safety, the Fiscal Office & Student Affairs Administrator)

Name: Last _____ First _____ M _____

Local Address _____ City _____ State _____ Zip _____

Permanent Address _____ Phone _____

City _____ State _____ Zip _____

Sex: [ ] Male [ ] Female Date of Birth_____

Employee/Student ID#_____

Nature of Injury

[ ] Abrasion [ ] Fracture [ ] Scratches
[ ] Amputation [ ] Illness [ ] Seizure
[ ] Bruise [ ] Inhalation [ ] Sting-Insect
[ ] Burn [ ] Laceration [ ] Sprain
[ ] Cut [ ] Puncture

Injured Body Part [ ] Right [ ] Left

[ ] Ankle [ ] Face [ ] Knee
[ ] Arm [ ] Finger [ ] Leg
[ ] Back [ ] Foot [ ] Nose
[ ] Elbow [ ] Hand [ ] Scalp
[ ] Eye [ ] Head [ ] Tooth
[ ] Wrist

Other:_____

Circumstances / Conditions

[ ] Fall [ ] Inadequate Guards / Protection
[ ] Weather [ ] Inadequate Ventilation
[ ] Improper Lifting [ ] Inadequate Illumination
[ ] Horseplay [ ] Participation in Athletics
[ ] Struck by Object [ ] Using Equipment Improperly
[ ] Alcohol / Drug Use

Other:_____

Treatment: What Immediate Action Was Taken?

Did the person require medical treatment? [ ] Yes [ ] No

Was the person sent home? [ ] Yes [ ] No

Was the person referred to a physician? [ ] Yes [ ] No

Name of Physician:_____

Was First Aid treatment provided: [ ] Yes [ ] No

If yes, by whom?_____

Did person go to a hospital? [ ] Yes [ ] No
If yes, where_____
Who transported?_____

Did the person refuse recommended medical treatment? [ ] Yes [ ] No

Date of Accident:_____

Time of Accident:_____[ ] AM [ ] PM

Location of Accident:_____

Status: [ ] Student [ ] Student Employee, Dept:_____

[ ] Staff. Dept.:_____

[ ] Visitor, Activity:_____

Environmental Conditions: [ ] Rain [ ] Snow [ ] Ice

Other, specify:_____

Name of Instructor/Supervisor in Charge and Department:

_____

Please describe the incident/injury in detail. Include how or why the injury occurred and specify the injury that resulted. Please print. Attach other sheets if needed.

_____

_____

_____

_____

_____

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_____

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_____

_____

_____

_____

_____

Signature of Person Completing Report:_____

_____

Incident / Injured Persons Signature:_____

_____

Copies Routed to: Originals to Human Resource for distribution

Reviewed by:_____
Date:_____

BWC
Better Workers' Compensation
Built with Pride in Ohio

First Report of an Injury, Occupational Disease or Death

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by: knowingly misrepresenting or concealing facts, making false statements, or accepting compensation to which he/she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

Injured Worker and Injury/Disease/Death Info.

Last name, first name, middle initial | Social Security number | Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Date of birth

Home mailing address | Sex ☐ Male ☐ Female | Number of dependents

City | State | 9-digit ZIP code | Country if different from USA | Department name

Wage rate $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____ | What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat | Regular work hours From _____ To _____

Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ YES ☐ NO If yes, please explain. | Occupation or job title

Employer name
Hocking College

Mailing address (number and street, city or town, state, ZIP code and county)
3301 Hocking Parkway Nelsonville, Ohio 45764-9704

Location, if different from mailing address

Was place of accident or exposure on employer's premises? ☐ YES ☐ NO
If no, give accident location, street address, city, state and ZIP code)

Date of injury/disease | Time of injury _____ ☐ AM ☐ PM | If fatal, give date of death | Time employee began work _____ ☐ AM ☐ PM | Date last worked | Date returned to work

Date hired | State where hired | Date employer notified

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death | Type of injury/disease and part(s) of body affected (For example: sprain of lower left back, etc.)

Benefit Application/Medical Release *– I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological, and/or psychiatric information that is related causally or historically to physical or mental injuries relevant to issues necessary to the administration of my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization, and any authorized representatives. I further authorize the Ohio Rehabilitation Services Commission to release information about my physical, mental, vocational and social conditions that is related causally and historically to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.*

Injured worker signature | Date | Telephone number ( ) | Work number ( )

Treatment Info.

Health care provider name | Telephone number ( ) | Fax number ( ) | Initial treatment date

Street address | City | State | 9-digit ZIP code

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ YES ☐ NO | Is the injury causally related to the industrial incident? ☐ YES ☐ NO

Health care provider signature | 11-digit BWC provider number | Date

Employer Info.

Employer policy number
30007021

CHECK IF ☐ Employer is self-insuring ☐ Injured worker is Owner/Partner/Member of Firm

Telephone number
(740) 753-3591

Fax number ( ) | E-mail address | Federal ID number | Manual number

Was employee treated in an emergency room? ☐ YES ☐ NO | Was employee hospitalized overnight as an in-patient? ☐ YES ☐ NO

If treatment was given away from worksite, provide the facility name, street address, city, state, ZIP code

☐ **CERTIFICATION** - The employer certifies that the facts in this application are correct and valid.

☐ **REJECTION** - The employer rejects the validity of this claim for the following reason(s) below:

FOR SELF-INSURING EMPLOYERS ONLY
☐ **CLARIFICATION** - The employer clarifies and allows the claim for the condition(s) below:

Employer signature and title | Date | OSHA case number

BWC
Better Workers' Compensation
Built with you in mind.

INSTRUCTIONS:
- Physician must complete this form when the injured worker is under work restrictions or is temporarily totally disabled.
- A copy of the completed form must be sent/faxed to the MCO and a copy given to the injured worker at time of exam.
- Any other physician-generated document may be used provided that the substitute document contains, at a minimum, the data elements on the MEDCO-14.
- If injured worker is employed by a self-insuring employer complete this form and mail or fax to the self-insuring employer.

Physician's Report of WORK ABILITY

FAX NOTE:

To	From
Toll-free phone number	Phone number
Toll-free fax number	Fax number

Injured worker name	Claim number	SSN if claim number unknown	Date of injury
			/ /
Injured worker occupation	**Employer name**		

WORK ACTIVITY

☐ May RTW with no restrictions on _____

☐ May RTW with restrictions
from _____ to _____
(complete work/non-work capabilities on the right). Work restrictions apply to work and non-work activity. If restrictions cannot be met at work, then injured worker is recommended to be off work.

The restrictions are ☐ permanent ☐ temporary? If temporary, how long? _____

☐ Is totally disabled from work
from _____ to _____ .
Please explain in the space provided below why the injured worker is unable to work, due to work-related injury/disease. List ICD-9 codes for the allowed conditions being treated which prevent return to work. _____

Estimated RTW date _____

Work/Non-Work Capabilities

% of Workday (8hr) Repetitions per hr	None at all 0%	Occasional 1-33% 4-6	Frequent 34-66% 6-12	Continuous 67-100% >12
Lift/Carry				
Up to 10 lbs.	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21-50 lbs.	☐	☐	☐	☐
51-100 lbs.	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Twist/turn	☐	☐	☐	☐
Reach below knee	☐	☐	☐	☐
Push/pull	☐	☐	☐	☐
Squat/kneel	☐	☐	☐	☐
Stand/walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐

Hand restrictions ☐ Left ☐ Right
- ☐ Must wear splint
- ☐ No lifting greater than _____ lbs
- ☐ No repetitive activities
- ☐ No work with hot or cold substances

No use of ☐ Left ☐ Right
- ☐ Arm
- ☐ Hand
- ☐ Finger _____
- ☐ Other

☐ Change positions every _____ ☐ Work activity as splint/bandage permits
☐ Avoid driving ☐ Keep wound clean/dry ☐ Limit working to _____ Hrs./Day

Physician's further explanation of work abilities or why the injured worker is unable to perform any work: _____

MMI

Has the work-related injury(s) or occupational disease reached a treatment plateau at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement): ☐ Yes ☐ No

▶ ***Note: Periodic medical treatment may still be requested and provided.***

IF YES, give date _____ **IF NO, please explain (attach additional sheet if necessary)**

REHAB

☐ **Check if vocational rehabilitation return to work services are indicated.**

Physician name and address ***(please print, type or stamp)***

Date of this exam	Follow-up appointment Date	Time
/ /	/ /	

I certify that the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment, or both.

Physician signature ***(mandatory)*** **Date** / /

BWC-3914 (08/28/01)
MEDCO-14

Distribution: White-Physician Fax a copy to MCO Yellow-Injured worker

OHIO BUREAU OF WORKERS' COMPENSATION

REQUIRED POSTING

Effective October 13, 2004, Section 4123.54 of the Ohio Revised Code requires notice of rebuttable presumption. Rebuttable presumption means that an employee may dispute or prove untrue the presumption (or belief) that alcohol or a controlled substance not prescribed by the employee's physician is the proximate cause (main reason) of the work-related injury.

The burden of proof is on the employee to prove that the presence of alcohol or a controlled substance was not the proximate cause of the work-related injury. An employee who tests positive or refuses to submit to chemical testing may be disqualified for compensation and benefits under the Workers' Compensation Act.

THIS LANGUAGE MUST BE CONSPICUOUSLY POSTED