Dear Insured:

West Bend is pleased to provide you with …

1. Workers' Compensation reporting tips that are helpful when you must report a work-related injury.
2. Employer's First Report of Injury or Disease form.
3. Supervisor's Incident Report.
4. A description of our cost containment initiatives.

The following forms are also available and are helpful in returning your employee to work …

1. **Job Analysis.** (WB 501) Use this form when working with the treating physician.
2. **Attending Physicians Return to Work Recommendations Record.** (WB 531) Send this with the injured employee to the initial treating doctor's appointment. You may ask the employee to return the form directly to you after initial medical treatment, or ask the doctor to fax it back to you.
3. **Return to Work Log.** (WB 603) Use this log as an efficient method to monitor and document the specific tasks your employees are performing while on light or modified duty.

We hope you find this information useful.

Sincerely,

Workers' Compensation Claim Department

WORKERS' COMPENSATION
REPORTING TIPS

– ATTENTION–
YOU MAY BE FINED IF YOU DO NOT REPORT ON THE JOB INJURIES PROMPTLY

If an accident occurs at your workplace, you must complete an Employers First Report of Injury form IMMEDIATELY and forward the form to us even if you don't have all the information about the injury. If the form isn't submitted to us soon after the injury occurs, you may be fined by the State.

When reporting an injury:

- Do not wait for medical bills.
- Do not withhold or delay reporting the loss because you believe the claim is questionable. Reporting a loss is not an admission of liability.
- Be sure to include your policy number on all correspondence you send to us.

You can report an injury by mail, phone, fax, or email.

Workers' Compensation Claims Department
PO Box 620976
Middleton, WI 53562
Phone: 877-922-5246
Fax: 877-434-9585
Email: nsiwcclaims@wbmi.com

Do not withhold the loss report for any reason. Send, fax, call, or e-mail it **IMMEDIATELY** after the injury occurs. **You may be fined** if the claims administrator cannot make the initial lost time payment because you failed to send the Employer's First Report of Injury on time.

If you fax or e-mail the report, please do not send it. If you need to notify your agent, please send your agent a photocopy of the report. Direct reporting saves time.

If you have any questions, please call your claims administrator.

HOW TO WRITE INJURY DESCRIPTIONS

The following instructions will help you avoid some common errors and save time when describing an injury on the First Report of Injury form.

For most accidents, you can describe what happened in one or two sentences. "He strained his lower back lifting a box." "She bruised her left knee when she fell on a wet floor." However, your descriptions must be specific. "Hurt back working" does not provide enough information.

Answer the following questions when describing an injury:

1.What part of the body was injured?

- Lower back
- Upper right leg
- Right forearm
- Third toe on left foot

2. How did the accident happen?

- Did the person fall?
- Did they twist their body as they got out of a chair?
- Were they moving or stationary when the accident happened?

3. Was the injured person carrying anything?

Even if it probably didn't cause the injury, we need to know if the person was carrying anything. For example, "Carrying broom, stepped wrong and twisted left ankle."

4. What specifically appears to have caused the accident?

If someone hurt their back lifting a box, say that. Don't say:

- Lifting a unit of material
- Lifting equipment
- They hurt their back lifting product

Avoid jargon or trade names for equipment. Explain precisely what they were doing.

- Lifting an air conditioner
- Carrying magazines
- Pushing a cart
- Bending over to pick up a wrench

If a machine caused the injury, tell us what kind.

- A grinder
- A shear
- A hoist

Again, avoid jargon or trade names.

5. What injury appears to have resulted?

- Strain
- Bruise
- Fracture
- Cut

Please be sure to include the injured person's birthdate and Social Security number. Also, indicate the geographical location of the accident (city, county and state).

WORKERS' COMPENSATION

is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

1. **GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation, the PPP counts as one of your two choices of providers.

2. **NOTIFY YOUR EMPLOYER.** You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.

3. **LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

   If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

   It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.

4. **KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

   Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free:	866/352-3033	Chicago:	312/814-6611	Peoria:	309/671-3019	Springfield:	217/785-7087
Web site:	www.iwcc.il.gov	Collinsville:	618/346-3450	Rockford:	815/987-7292	TDD (Deaf):	312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.

Party handling workers' compensation claims	**WEST BEND MUTUAL INSURANCE COMPANY**		
Business Address	**1900 SOUTH 18TH AVENUE, WEST BEND, WI 53095**		
Business Phone	**1-800-236-5004**		
Effective Date		Termination Date	
Policy Number		Employer's FEIN	

INDEMNIZACIÓN DEL TRABAJADOR

Es un sistema de beneficios que provee la ley a la mayor parte de trabajadores que se han lastimado o han contraído una enfermedad relacionada con su trabajo. Los beneficios se pagan en casos donde las lesiones han ocurrido parcial o totalmente por el trabajo del empleado. Estas lesiones pueden ser el empeoramiento de una condición que previamente existía, lesiones ocasionadas por el uso repetitivo de una parte del cuerpo determinada, ataques al corazón o cualquier otro problema causado por las condiciones de trabajo. Dichos beneficios se le pagan al empleado sin importar de quien haya sido la culpa.

SI USTED SUFRE DE UNA ENFERMEDAD O LESIÓN RELACIONADA CON SU TRABAJO, USTED DEBE DE HACER LO SIGUIENTE:

1. **BUSQUE ASISTENCIA MEDICA.** Por ley, su patrón esta obligado a pagar por todos los servicios médicos que se requieran para curar o aliviar los efectos de su enfermedad o lesión. El empleado puede escoger a dos médicos, cirujanos u hospitales. En casos necesarios, el empleador también tendrá que pagar por rehabilitación física, mental o vocacional dentro de los términos que antes se hayan establecido.
2. **NOTIFIQUE A SU PATRON.** Usted cuenta con 45 días para informarle, oralmente o por escrito, a su patrón acerca de su accidente o enfermedad. Para evitar posibles retrasos, se recomienda que usted incluya en este reporte, su nombre, dirección, número de teléfono, número de seguro social y una breve descripción de su lesión o enfermedad.
3. **SEPA CUALES SON SUS DERECHOS.** Por ley, su patrón esta obligado a reportar cualquier accidente que resulte en la pérdida de tres o mas días de trabajo a la Comisión de Indemnización del Trabajador. Una vez que se haya hecho el reporte, usted recibirá un manual en el cual se explica la ley, los beneficios y el tramite en general. Si usted necesita un manual, por favor llame a Comisión o visite su sitio Web.

   Si usted tiene que perder días de trabajo para recuperarse de su lesión o enfermedad, usted puede tener el derecho de recibir pagos semanales y el cuidado médico necesario hasta que usted esté capacitado para regresar. Su posición deberá estar razonablemente disponible para usted.

   Es en contra de la ley que su patrón lo acose, lo despida, le niegue contratarlo nuevamente o lo discrimine por darle seguimiento a los derechos con que usted cuenta bajo la Indemnización del Trabajador o los Decretos de Enfermedades Ocupacionales (Occupational Diseases Acts). Si usted presenta una demanda fraudulenta, usted puede ser penado por la ley.
4. **MANTENGASE DENTRO DE LOS LIMITES.** Generalmente las demandas deben presentarse en el transcurso de tres años después de que haya sucedido el incidente relacionado con su trabajo o dos años después de haber recibido su último pago de indemnización del trabajador. Presente la demanda de acuerdo lo que haya sucedido mas recientemente. Demandas que tengan que ver con neumoconiosis, exposición radiológica, asbestosis o enfermedades similares, tienen requisitos especiales.

   Los trabajadores cuya incapacidad ha empeorado, tienen derecho de abrir su caso nuevamente en el transcurso de 30 meses después de haber recibido su indemnización. Los empleados que acordaron recibir una cantidad fija en su contrato con la Comisión, no podrán abrir su caso nuevamente. Solamente aquellos casos aprobados por la Comisión, podrán abrirse nuevamente.

Para obtener mas información visite el sitio Web de Illinois Workers' Compensation o llame a cualquiera de estas oficinas:

Gratis:	866-352-3033	Chicago:	312-814-6611	Peoria:	309-671-3019	Springfield:	217-785-7087
Sitio Web:	www.iwcc.il.gov	Collinsville:	618-346-3450	Rockford:	815-987-7292	TDD (para sordos):	312-814-2959

POR LEY, TODO EMPLEADOR DEBERA COMPLETAR LA INFORMACION A CONTINUACION Y TENER ESTE AVISO EN UN LUGAR VISIBLE EN EL LUGAR DE TRABAJO			
Encargado del manejo de las demandas de la indemnización del trabajador	**WEST BEND MUTUAL INSURANCE COMPANY**		
Dirección del negocio	**1900 SOUTH 18TH AVENUE, WEST BEND, WI 53095**		
Teléfono del negocio	**1-800-236-5004**		
Fecha de vigencia		Fecha de finalización	
Número de la póliza		FEIN del empleado	

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? Yes / No
Employer's name		Doing business as	
Employer's mailing address			
Nature of business or service		SIC code	
Name of workers' compensation carrier/admin. **West Bend Mutual Insurance Co. / Fax: 262-334-6378**	Policy/Contract #		Self-insured? Yes / No
Employee's full name			Birthdate
Employee's mailing address			Employee's e-mail address

Male / Female	Married / Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired

Time employee began work **AM PM**	Date and time of accident	Last day employee worked
If the employee died as a result of the accident, give the date of death.	Did the accident occur on the employer's premises? Yes / No	
Address of accident		
What was the employee doing when the accident occurred?		
How did the accident occur?		
What was the injury or illness? List the part of body affected and explain how it was affected.		
What object or substance, if any, directly harmed the employee?		
Name and address of physician/health care professional		
If treatment was given away from the worksite, list the name and address of the place it was given.		

Was the employee treated in an emergency room? Yes / No	Was the employee hospitalized overnight as an inpatient? Yes / No

Report prepared by	Signature	Title and telephone #

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE ROAD SPRINGFIELD, IL 62703-5118**
By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any sense. This information is confidential. IC45 11/11

FORMULARIO 45 – ILLINOIS: PRIMER INFORME DE LESIÓN DEL EMPLEADOR

Escriba a máquina o en letra de imprenta

FEIN del empleador	Fecha del informe	N.° de caso o archivo	¿Es este un caso con días de trabajo perdidos?
Nombre del empleador		Nombre comercial	
Dirección postal del empleador			
Naturaleza del negocio o servicio		Código SIC	
Nombre de la aseguradora o el administrador de la compensación laboral **West Bend Mutual Insurance Co. / Fax: 262-334-6378**	Póliza/N.° de contrato		¿Autoasegurado?
Nombre completo del empleado	Número de seguro social		Fecha de nacimiento
Dirección postal del empleado			Dirección de correo electrónico del empleado
¿Hombre/Mujer?	¿Soltero/Casado?	Número de dependientes	Salario semanal promedio del empleado
Nombre del cargo u ocupación		Fecha de alta	
Hora a la que el empleado comenzó a trabajar	Fecha y hora del accidente	Último día que trabajó el empleado	
Si el empleado murió como consecuencia del accidente, dé la fecha de la muerte		¿Ocurrió el accidente en el local del empleador?	
Dirección donde ocurrió el accidente			
¿Qué estaba haciendo el empleado cuando ocurrió el accidente? ¿Cómo ocurrió el accidente?			
¿Cuál fue la lesión o enfermedad? Escriba la parte del cuerpo afectada y explique cómo fue afectada			
¿Qué objeto o sustancia, si lo hubo, le hizo daño directamente al empleado?			
Nombre y dirección del médico o profesional de atención sanitaria			
Si se proveyó tratamiento fuera del lugar de trabajo, escriba el nombre y la dirección del lugar donde fue provisto.			
¿Fue tratado el paciente en una sala de urgencias?	¿Estuvo el empleado hospitalizado de un día para otro?		
Informe preparado por	Firma	Cargo y número de teléfono	

Por favor, envíe este formulario a:
ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE ROAD SPRINGFIELD, IL 62703-5118
Por ley, los empleadores deben mantener registros exactos de todas las lesiones y enfermedades relacionadas con el trabajo (excepto ciertas lesiones

menores).
Los empleadores deben informar a la Comisión de todas las lesiones que den lugar a la pérdida de más de tres días programados de trabajo.
El presentar este formulario no afecta la responsabilidad bajo la Ley de Compensación por Accidentes de Trabajo y no es en ninguna forma incriminatorio. Esta información es confidencial. IC45 6/09

SUPERVISOR'S INCIDENT REPORT

☐ Injury (work related) ☐ Illness (work related) ☐ Property Damage ☐ Incident

Employee Name (First, Middle, Last)	Social Security Number	Sex ☐ Male ☐ Female	Employee Home Telephone Number

Employee's Street Address	City	State	Zip

Age	Birthdate Mo. Day Yr.	Job Title	Department

Employee's Scheduled Work Week When Injured	Start Time AM PM	End Time AM PM	Hrs. Per Day	Hrs. Per Wk.	Days Per Wk.	Normal Full-Time Schedule for Injured's Work	Start Time AM PM	End Time AM PM

Injury Date Mo. Day Yr.	Hour of Day AM PM	Last Day Worked Mo. Day Yr.	Start Date Mo. Day Yr.	☐No Lost Time ☐Date Returned to Work Mo. Day Yr. ☐Estimated Date of Return

Did employee seek medical attention? ☐ Yes ☐No If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will the employee complete a drug screening?

Yes No

Names of Witnesses (Attach witness statements.)

1. _____ 2. _____

Injured Employee's statement of what happened. (Identify circumstances and equipment involved.)

_____

_____

_____

How could this incident have been prevented?

_____

_____

_____

What corrective action has been taken?

_____

_____

_____

What is the injury/illness? (Be specific.)

Part of Body Affected

- ☐ Eye
- ☐ Head
- ☐ Neck
- ☐ Back
- ☐ Arm
- ☐ Shoulder
- ☐ Fingers
- ☐ Leg
- ☐ Knee
- ☐ Hip
- ☐ Foot
- ☐ Wrist
- ☐ Hand
- ☐ Toes
- ☐ Ankle
- ☐ Elbow
- ☐ Trunk (Other than back)
- ☐ Other

Type of Injury

- ☐ Cut/Abrasion
- ☐ Bruise/Contusion
- ☐ Foreign Object
- ☐ Burn
- ☐ Break
- ☐ Sprain/Strain
- ☐ Exposure
- ☐ Repetitive Motion
- ☐ Other

_____ _____

I believe that the answers to the above questions are true to the best of my knowledge.

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____

Notified

WORKERS COMPENSATION
COST CONTAINMENT INITIATIVES

West Bend Mutual Insurance Company participates in several medical cost containment initiative programs. The use of these programs helps reduce your workers' compensation expenses. A brief summary of each program is outlined below.

If you have any questions about any of the programs we offer, please call our Workers' Compensation Claim Department at 1-800-236-5004.

PHARMACY PROGRAM

This program is designed to provide discounts on workers' compensation prescriptions submitted by your injured employees. This service is provided by a national pharmaceutical management company using a network of retail pharmacies.

How the program works:

1. The injured employee files a workers' compensation claim with employer, seeks medical treatment, and receives a prescription from a physician.
2. The injured employee presents the prescription along with the temporary ID form to a participating pharmacy where the claim is electronically submitted by the pharmacy to our vendor.
3. Once West Bend receives notification of the claim from the employer, an employee-specific ID drug card is issued, along with a list of participating pharmacies and instructions on the use of the program.
4. The injured employee presents the ID drug card to a participating pharmacy for any future workers' compensation prescriptions.
5. High-cost/long-term-use medications are conveniently supplied through our vendor's mail service pharmacy.

DIAGNOSTIC TESTING PROGRAM

Using the services of a diagnostic management vendor, we can save money on any diagnostic test (i.e., CT scans, MRIs, EMGs, etc…) the treating doctor orders for injuries an employee sustains in a work-related injury. Our vendor will schedule the test, then notify the injured employee of the date and time. Once the test is performed, the films/x-rays will be forwarded to the referring physician.

To make this program successful, we ask that you encourage your employees to contact their West Bend claim representative as soon as they know a test will be ordered. We will handle it from there.

MEDICAL COST CONTAINMENT

Strong medical management brings about the early and safe return to work of your employees and reduces claim costs. To accomplish this, we contract with a medical bill review service. All of our medical provider charges (hospital, physician, physical therapist, chiropractor, and pharmaceutical) are verified for the appropriateness of the charge, and to determine if they adhere to state mandated fee schedules or local usual and customary (U&C) reimbursement levels.

Another way we are containing costs is through the use of a PPO Network. The Preferred Providers have agreed to discount their billings for the treatment of your industrially injured employees. This in turn keeps your premium costs down.

Your support in encouraging your injured workers to use a PPO provider is important. It sends an important message to the medical care providers that we support them in their effort to offer quality, cost effective care to patients.

For a list of PPO's in your area, please visit our website, www.thesilverlining.com for a link to the PPO list. Click on the "Claims" tab and then click on”How to Report a Claim" for the link “PPO Directory.” The link is found toward the bottom of the webpage.

WEST BEND MUTUAL INSURANCE COMPANY
WORKERS' COMPENSATION PRESCRIPTION INFORMATION

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

Employee Name:	
Group #:	10602270
Member ID (SSN):	
Date of Injury:	
Claim Number:	
Processor:	myMatrixx
Bin #:	014211
Day supply is limited to 3 days for a new injury	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:

Injured Worker:

West Bend has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. ***myMatrixx*** has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call ***myMatrixx*** toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATIONS(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist: Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling ***myMatrixx*** for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All other will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

AUTHORIZATION TO DISCLOSE NON-PUBLIC PERSONAL HEALTH INFORMATION AND WAIVER OF PRIVILEGE

TO:

Patient Name:
Claim Number:

1. I, _____, hereby authorize the above named health care provider to give to, release, and permit copies to be made of all health care records that are in your possession.
2. The health care records should be disclosed to any authorized representative of West Bend Mutual Insurance Company. West Bend Mutual Insurance Company is the insurer for the employer and acts as its agent for insurance purposes.
3. The purpose of the disclosure of these records is to aid West Bend Mutual Insurance Company's evaluation of my claim.
4. West Bend Mutual Insurance Company may re-disclose my records to others retained by West Bend Mutual Insurance Company to assist in the evaluation of my claim, and thus, my records may no longer be private.
5. The type of information to be disclosed may include, but is not limited to, x-rays, x-ray reports, summaries, reports, narratives, test results, notes and any other health care records from all in-patient and out-patient visits at your institution or facility.
6. This authorization also permits release of all information relating to treatment for:
   (a) drug and/or alcohol abuse;
   (b) any mental disease, defect, or psychological/psychiatric condition;
   (c) any communicable disease, AIDS, or AIDS-related disease.
7. I further authorize the provider to release any information in their possession and to meet with, discuss with, and/or to correspond and report directly to West Bend Mutual Insurance Company or any representative it may designate to discuss my medical and/or psychological condition(s) and/or treatment. These authorized communications may be initiated by the treatment provider. I also waive the right that I may have to be notified of these communications and to be present at consultations.
8. I understand that executing this authorization is a waiver of my privilege of physician-patient confidentiality, and I freely and voluntarily waive that privilege.
9. The above-named health care provider may not condition treatment, payment, enrollment or eligibility of benefits on obtaining your authorization.
10. A photocopy or facsimile of this authorization shall be valid and effective just as the original.
11. I understand that I may revoke this authorization, in writing to the records department of the above named health care provider, at any time, except where information has already been released as a result of this authorization.
12. Unless revoked, this authorization shall remain in effect for the period of one year beyond the date of patient's signature, or until my claim is closed, whichever is later. Records may be disclosed whether dated before or after the date of this authorization.
13. I understand that I or my authorized representative is entitled to receive a copy of the completed authorization form.

Signature of Patient/Guardian:_____ Date: _____

Social Security Number: _____ Birth Date: _____

Witness Signature: _____ Date: _____

WB-1851 (07-06)

JOB ANALYSIS

Name	Claim Number
Employer	Address

Date of Hire	Date of Injury	Job Title	Check One ☐Skilled ☐Unskilled

Training Required to Learn Job

Was Employee Working as a Supervisor? ☐Yes ☐No	If Yes, Number of People Supervised	Employee Worked: ☐Alone ☐Small Group (3-5) ☐Large Group

Days Worked Per Week (Circle) M Tu W Th F Sat Sun	Hours Worked During Week From To Shift

Work Breaks (Daily Rest Periods and Lunch)

Morning	Lunch	Afternoon
— Minutes	— Minutes	— Minutes

Overtime Per Week Number of Hours	How Often	Was Employee Hired With Any Restrictions? (Check) ☐Yes ☐No

If Yes, Specify

Body Movements – Amount Spent Each Day

Sitting % Standing % Walking %

Check Appropriate Column	None	Occasionally (1/3 or Less)	Frequently (1/3 – 2/3)	Continuously (2/3 or more)
Reaching above shoulder length				
Working with body bent over at waist				
Working in kneeling position				
Crawling				
Bending, stooping, squatting				
Repetitive foot movements as in foot controls – L/R or both				
Climbing stairs				
Climbing Ladders				
Working with arms extended at shoulder level				
Working with arms above shoulder height				

Height from floor of object to be reached and/or worked on (use space for drawing, if needed):

Object Height

Weights Handled	Item	Alone or Assisted	Push, Pull Or Lift	Times Per Hour	Times Per Day	Times Per Week	Times Per Month
1 – 10 lbs.							
15 – 20 lbs.							
25 – 35 lbs.							
45 – 60 lbs.							
65 – 80 lbs.							
85 – 100 lbs.							

☐No lifting required for this job.

Hand Coordination Activities (Check Appropriate Column)				
Movement Required	Tool/Machine	Right	Left	Both
Major hand				
Fine Manipulation				
Gross Manipulation				
Simple Grasping				
Power Grip				
Hand Twisting				
Pushing				
Pulling				

Tools Used By Worker	Weight	No. of Hands Needed To Move

Objects Worker Must Move During Day	Weight	Distance	No. of Workers Needed To Move

Physical Surroundings Does Employee Work ☐Inside ___% ☐Outside ___%	Does Employee Walk On Uneven Ground? ☐Yes ☐ No
Does Employee Work Around Moving Machinery? ☐Yes ☐No Does Employee Drive Automotive Equipment? ☐Yes ☐No If yes, describe:	

Does the Employee Come In Contact With The Following? (Indicate Type)	Yes	No	Type
Fumes			
Dust			
Mist			
Steam			
Strong Odors			
Poor Ventilation			
Air Conditioning			

Characteristics Of Job That Cannot Be Modified By Employer For This Employee

Comments And/Or Observations

☐Job Site Evaluation Done	☐Narrative Discussion Only
Name(s) of Person(s) Interviewed	Title

Person Completing Analysis	Title	Date

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Claim No.

Patient's Name (First) (Middle Initial) (Last) | Date of Injury/Illness

TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK

Diagnosis/Condition (Brief Explanation)

I saw and treated this patient on _____ (date) and based on the above description of the patient's current medical problem:

1. ☐Recommend his/her return to work with no limitations on _____ (date)

2. ☐He/She may return to work on _____ (date) **capable of performing the degree of work checked below with the following limitations:**

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8 hour work day patient may:
   a. Stand/Walk
      ☐None ☐1-4 hours ☐4-6 hours ☐6-8 hours
   b. Sit
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
   c. Drive
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
2. Patient may use hand(s) for repetitive:
   ☐Single Grasping
   ☐Pushing & Pulling
   ☐Fine Manipulation
3. Patient may use foot/feet for repetitive movement as in operating foot controls:
   ☐Yes ☐No
4. Patient is able to:

	Frequently	Occasionally	Not At All
a. Bend	☐	☐	☐
b. Squat	☐	☐	☐
c. Climb	☐	☐	☐
d. Twist	☐	☐	☐
e. Reach	☐	☐	☐

Other Instructions and/or Limitations Including Prescribed Medications:

These restrictions are in effect until _____ (date) or until patient is re-evaluated on _____ (date)

3. ☐He/She is totally incapacitated at this time. Patient will be re-evaluated on _____ (date)

Physician's Signature | Date

West Bend Mutual Insurance Company
1900 South 18th Avenue
West Bend, Wisconsin 53095

RETURN TO WORK LOG

EMPLOYEE NAME _____ SUPERVISOR _____

Date	Hours Worked In	Hours Worked Out	Tasks Performed	Comments Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
Sunday / /						
Monday / /						
Tuesday / /						
Wednesday / /						
Thursday / /						
Friday / /						
Saturday / /						

I clearly understand, take responsibility for, and acknowledge the limitations my physician, Dr. _____ has placed on me while participating in this temporary transitional work program.

_____ _____
Employee Signature Date

RETURN TO WORK LOG INFORMATION

The Return To Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty. It helps eliminate potential conflicts should the question arise regarding the employee performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employee's restrictions to the log.
- Have employee write name on top of log and the Supervisor write their name.
- Remind employee it is their responsibility to follow the restrictions.
- Remind employee that the restrictions apply to occupational AND non-occupational activities.
- Employee and supervisor review all tasks completed each day, indicate any concerns and everyone signs the form.