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 620978
Middleton, WI 53562
Phone: 800-760-9250, option 1, then option 7
Fax: 877-434-9585
e-mail: nsiclaims@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 or age and Social Security number. Also, indicate the geographical location of the accident (city, county and state).

NSI
A DIVISION OF
WEST BEND
A MUTUAL INSURANCE COMPANY™

# YOUR RETURN-TO-WORK PROGRAM

**What Is A Return-To-Work Program?**

A return-to-work program is a proactive way to help injured workers return to productive and safe employment as soon as physically possible. It is a partnership involving employers, workers, health care providers, and the insurance company. The partnership has one shared goal: to return injured workers to safe and suitable work.

**Why Introduce A Return-To-Work Program?**

Workplace injuries are costly to all members of today's workplace partnership. While accident prevention is the best way to reduce overall injury costs, the implementation of an effective return-to-work program helps to guarantee that each injured worker receives prompt health care and early assistance during both the initial stages of recovery and the subsequent return to productive employment

**Key Steps to a Successful Return-To-Work Program**

- Involve and communicate with your workforce
- Organize a Joint Return-To-Work Committee
- Select a Return-To-Work Manager
- Evaluate the needs of your workplace
- Develop a Return-To-Work policy and define the program's scope
- Formulate the objectives of your Return-To-Work Program
- Review your worksite accident history
- Create rules and processes
- Conduct a job task analysis
- Develop light duty activities
- Create and utilize an information package
- Facilitate communication, education and promotion
- Evaluate the results of your program

**The Claim Process:**

1. Injury occurs and employee reports a claim.
2. Employers First Report of Injury is filed with the insurance carrier within 24 hours.
3. Employee incident report is completed by the injured employee.
4. Supervisor incident report is completed by the supervisor.
5. File the Employee and Supervisors Reports, along with any other investigation results to the insurance carrier.
6. Employer explains WC rights and responsibilities to the employee.
7. Employer provides the employee a restricted duty form for the physician to complete. One of the following will occur;
   A. The employee will return to fulltime, unrestricted work.
   B. The employee will be authorized off of work by the physician.
      * The employer should contact the physician regarding the R-T-W policy and procedure.
      * Follow up with the injured employee weekly to discuss R-T-W options.
      * Once R-T-W restrictions become available, advise the claimant in writing of odder to provide restricted work.
   C. The employee will return to work within restricted duty.
      * W/C Coordinator communicates restrictions to supervisor and insurance carrier.
      * Follow up with employee weekly to monitor progress.
   D. The employee will return to work without a release or clear restrictions. The employer should do one of the following:
      * Call the physician to clarify restrictions and request R-T-W forms.
      * Fax, mail or deliver a letter outlining the availability of restricted work, along with R-T-W form to the physician.
8. Employer continues to monitor and gather information regarding treatment and R-T-W. Provide this information to the insurance carrier to ensure prompt handling of the claim and coordinated R-T-W efforts.
9. Review progress of the claim with the insurance carrier on a quarterly basis or until closure of the claim.

# INDIANA
# WORKER'S COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Worker's Compensation Act of the state of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The worker's compensation insurance carrier or the administrator for:

_____
(name of company)

is:

**WEST BEND MUTUAL INSURANCE COMPANY**
(name of carrier/administrator)

**1900 SOUTH 18TH AVENUE**
(mailing address)

**WEST BEND, WISCONSIN 53095**
(city, state, zip)

**1-800-236-5004 or 262-334-6430**
(telephone number)

**WORKER'S COMPENSATION CLAIMS DEPARTMENT**
(contact person)

For more information about rights or procedures under the Indiana Worker's Compensation system, call or write:

Worker's Compensation Board of Indiana
Ombudsment Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

# INDIANA WORKER'S COMPENSATION
# FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

Please return completed form electronically by an approved EDI process.

| FOR WORKER'S COMPENSATION BOARD USE ONLY | | |
|---|---|---|
| Jurisdiction | Jurisdiction claim number | Process date |
| | | |

**PLEASE TYPE or PRINT IN INK**

*NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.*

## EMPLOYEE INFORMATION

| Social Security number | Date of birth | Sex ☐ Male ☐ Female ☐ Unknown | Occupation / Job title | NCCI class code |
|---|---|---|---|---|
| | | | | |

| Name (*last, first, middle*) | Marital status ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown | Date hired | State of hire | Employee status |
|---|---|---|---|---|
| Address (*number and street, city, state, ZIP code)* | | Hrs / Day / Days / Wk / Avg Wg / Wk | | ☐ Paid Day of Injury ☐ Salary Continued |
| Telephone number (include area code) | Number of dependents | Wage $ Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other | | |

## EMPLOYER INFORMATION

| Name of employer | Employer ID# | SIC code | Insured report number |
|---|---|---|---|
| | | | |

| Address of employer (*number and street, city, state, ZIP code*) | Location number / Telephone number | Employer's location address (*if different*) |
|---|---|---|
| | Carrier / Administrator claim number | OSHA log number / Report purpose code |

Actual location of accident / exposure (*if not on employer's premises*):

## CARRIER / CLAIMS ADMINISTRATOR INFORMATION

| Name of claims administrator<br>**West Bend Mutual Insurance Company** | Carrier federal ID number<br>**39-0698170** | Check if appropriate ☐ Self Insurance |
|---|---|---|
| Address of claims administrator (*number and street, city, state, ZIP code*)<br>**1900 S. 18th Avenue, West Bend, WI 53095** | ☒ Insurance Carrier | Policy / Self-insured number |
| Telephone number **800-334-5004** / Fax number **262-334-6378** | ☐ Third Party Admin. | Policy period From To |
| Name of agent | Code number | |

## OCCURRENCE / TREATMENT INFORMATION

| Date of Inj. / Exp. | Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined | Date employer notified | Type of injury / exposure | Type code |
|---|---|---|---|---|
| Last work date | Time workday began | Date disability began | Part of body | Part code |
| RTW date | Date of death | Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No | Name of contact | Telephone number |

| Department or location where accident / exposure occurred | All equipment, materials, or chemicals involved in accident |
|---|---|
| Specific activity engaged in during accident / exposure | Work process employee engaged in during accident / exposure |

How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.

Cause of injury code

Name of physician / health care provider

Hospital or offsite treatment *(name and address)*

INITIAL TREATMENT
- ☐ No Medical Treatment
- ☐ Minor: By Employer
- ☐ Minor: Clinic / Hospital
- ☐ Emergency Care
- ☐ Hospitalized > 24 Hours
- ☐ Future Major Medical / Lost Time Anticipated

| Name of witness | Telephone number | Date administrator notified |
|---|---|---|
| | | |

| Date prepared | Name of preparer | Title | Telephone number |
|---|---|---|---|
| | | | |

*An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).*

# INSTRUCTIONS

## General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.
2. Enter all dates in MM/DD/YY format.
3. Please return completed form electronically by an approved EDI process.
4. For answers to questions, please call (317) 232-3808.

## Definitions:

**AGENT NAME & CODE NUMBER:** Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

**ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED:** List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (*e.g. Acetylene cutting torch, metal plate, etc.*).

**AVG WG/WK:** Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc*.) and dividing by 52.

**CLAIMS ADMINISTRATOR:** Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

**CONTACT NAME / PHONE NUMBER:** Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc*.)

**DATE DISABILITY BEGAN:** The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised designated by statute.

**DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED:** If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc*.).

**EMPLOYEE STATUS:** Indicate the employee's work status from the following choices: Full-time, Part-Time, Apprentice Full-Time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as follows*: FT, PT, AFT*, *APT, VO, SW, PW, OS, DI, RE, NE or UK*).

**HOW INJURY / ILLNESS OCCURRED:** Describe the sequence of events leading to the injury or exposure (e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall).

**NCCI CLASS CODE:** A four-digit code classifying the occupation of the claimant.

**OCCUPATION / JOB TITLE:** Enter the primary occupation of the claimant at the time of the accident or exposure.

**PART OF BODY AFFECTED:** Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc*.).

**REPORT PURPOSE CODE:** 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

**RTW DATE (*Return to Work Date*):** Enter the date following the most recent disability period on which the employee returned to work.

**SIC CODE:** This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

**SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE:** Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

**TYPE OF INJURY / ILLNESS:** Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc*.)

**WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE:** Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).

# 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.

**QUALITY MEDICAL CARE (Applicable in Indiana and Iowa only)**

As your workers' compensation insurer, we share your goal of providing quality medical care to your injured workers so that they may return to the work force as soon as possible. In Indiana and Iowa, the employer and its insurance carrier have the responsibility for providing reasonable and necessary medical care when there is an injury and the ability to choose which physician or other medical practitioner that will provide the service. **In other words, it is the employer and insurance carrier who select the physician to treat an injury, not the injured employee.** If the employee refuses to accept medical services as instructed by the carrier, the right to receive compensation may be suspended during the period of refusal.

It has been our experience that one of the most effective ways to carry out our mutual responsibilities under the Indiana and Iowa Workers' Compensation Laws for an injured worker is for you, as an employer, to designate a company physician who is authorized to treat work-related injuries. This designation should be part of our internal procedure for reporting on-the-job injuries. Each employee should be instructed, particularly when first hired, on how to report an on-the-job injury and what physician is authorized for treatment. It should be made clear that except in cases of an emergency, no other medical or chiropractic care is authorized and charges incurred for those services will not be honored. Many of our employers put this policy in writing and have the employee sign and date this document.

There are many benefits to this policy. First, injured employees know exactly where to go for medical care when needed. Second, a good working relationship is established between the physician, you as an employer, and us as an insurance company. We find we get prompt answers to our questions and are able to better manage both medical costs and claims for weekly benefits. Referrals, particularly when an independent medical exam is needed, are greatly simplified. Where rehabilitation is needed, company physicians can assist our rehabilitation nurses and our vocational counselors.

We will be happy to work with you in designating a company physician and helping you implement this program. Please feel free to call the Workers' Compensation Claim Department with any questions or comments.

# 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

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**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

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

TO:

Patient Name:
Claim Number:
Birth Date:
Social Security No.:

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.

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.

The purpose of the disclosure of these records is to aid West Bend Mutual Insurance Company's evaluation of my claim.

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. Re disclosure of this protected health information will no longer be protected under the federal privacy rule.

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.

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.

I understand that executing this authorization is a waiver of my privilege of physician-patient confidentiality, and I freely and voluntarily waive that privilege.

The above-named health care provider may not condition treatment, payment, enrollment or eligibility of benefits on obtaining your authorization.

A photocopy or facsimile of this authorization shall be valid and effective just as the original.

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.

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.

I understand that I or my authorized representative is entitled to receive a copy of the completed authorization form.

_____ _____

Signature of Patient/Claimant Date

_____ _____

Signature of Parent/Guardian/Representative Date

# 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<br>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 |
|---|---|---|
| | | |



West Bend Mutual Insurance Company
West Bend, Wisconsin 53095

# 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.