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 forms.
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).

West Bend Mutual Insurance Company
West Bend, Wisconsin 53095

Minnesota Workers' Compensation Employee's rights and responsibilities

This notice is required by law to be posted in a conspicuous location wherever the employer is engaged in business.

If you are injured:

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not timely report the injury to your employer. The time limit may be as short as 14 days, although under certain circumstances, it may be longer.
- Provide your employer with as much information as possible about your injury so that a proper injury report can be filed.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO), you may treat with a doctor of your choice. Your employer must notify you if you are covered by a CMCO.
- Cooperate with all requests for information concerning your workers' compensation claim. Please note: the law provides that the workers' compensation insurer can obtain medical information specific to your work injury without your authorization, provided you are sent written notification of this request at the time the request is made.
- Get written confirmation from your doctor on any authorization to be off work.

What does workers' compensation pay for?

- Medical care for your work injury, as long as it is reasonable and necessary
- Wage-loss benefits for part of your lost income (There is a three-calendar-day waiting period before these benefits start.)
- Compensation for permanent damage to or loss of function of a body part
- Benefits to your spouse and/or dependents if you die as a result of a work injury
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer due to your work injury

What the insurance company must do:

- Investigate your claim promptly.
- Within 14 days of when the claimed injury occurred or when your employer became aware of it, either begin payment of benefits due or file a denial of liability, explaining why benefits are being denied.

Insurer name: **West Bend Mutual Insurance Company**	Phone number: **1-800-236-5010**

If the insurer accepts your claim for wage-loss benefits and you have been disabled for more than three calendar-days:

- The insurer will send you a copy of the Notice of Insurer's Primary Liability Determination form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

If the insurer denies your claim for wage-loss benefits:

- The insurer will send you a copy of the Notice of Insurer's Primary Liability Determination form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.
- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below to discuss your options.

Fraud

Collecting workers' compensation benefits you are not entitled to is theft. Any theft of more than $500 is a felony.

Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3.

A suspected fraud can be reported by anyone. If you have reason to suspect someone is committing workers' compensation fraud, call 1-888-FRAUD MN (1-888-372-8366). All suspected violations will be investigated.

If you have questions or need more help, call the Minnesota Department of Labor and Industry:

Worker's Compensation Hotline	Department of Labor and Industry	Department of Labor and Industry
1-800-DIAL-DLI	Workers' Compensation Division	Workers' Compensation Division
(1-800-342-5354)	443 Lafayette Road N.	5 N. Third Ave. W., Suite 400
8 a.m. to 4:30 p.m.,	St. Paul, MN 55155	Duluth, MN 55802
Monday-Friday	Phone: (651) 284-5032	Phone: (218) 733-7810
	TDD: (651) 297-4198	Toll-free: 1-800-365-4584

Your claim will be answered by experienced workers' compensation specialists who will provide instant, accurate information and assistance. Additional workers' compensation information is available on the department Web site at www.doli.state.mn.us.

August 2003 This document can be made available in alternative formats, such as Braille or audiotape, by calling (651) 284-5042 or (651) 297-4198/TDD.

MINNESOTA WORKERS' COMPENSATION SYSTEM EMPLOYEE INFORMATION SHEET

What does workers' compensation pay for?

- Medical care for the work injury, as long as it is reasonable and necessary
- Wage-loss benefits for part of your lost income (there is a three-calendar-day waiting period before these benefits start)
- Benefits for permanent damage or loss of function of a body part
- Benefits to your spouse and/or dependents if you die of a work injury
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer

How are workers' compensation benefits paid?

Your workers' compensation benefits are paid by an insurance company or your employer, if your employer is self-insured. State law sets the benefit levels. Please note: pursuant to statute, the insurer can obtain medical information specific to your work injury without your authorization.

If the insurer accepts your claim for wage loss benefits and you have been disabled for more than three calendar days:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

If the insurer denies your claim for wage loss benefits:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.

Insurer Name: West Bend Mutual Insurance Company **Phone: 800-236-5004**

- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below to see what to do next.

If you have other questions or need more help, call the Minnesota Department of Labor and Industry Workers' Compensation Hotline:

Twin Cities and Southern Minnesota: **(651) 284-5005 or 1-800-342-5354; TTY (651) 297-4198**

Duluth and Northern Minnesota: **(218) 733-7810 or 1-800-365-4584**

Your call will be answered by experienced workers' compensation specialists, who will provide **instant, accurate information and assistance.**

Additional workers' compensation information is available on the department's Web site at:

www.doli.state.mn.us.

Your employer is required by law to give you this information. This material can be made available in different formats, such as large print, Braille, or on audiotape, by calling the numbers printed above.

Minnesota Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road North
St. Paul, MN 55155-4305
(651) 284-5030

First Report of Injury

See Instructions on Reverse Side
Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

FR01

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA Case #				
3. DATE OF CLAIMED INJURY	4. Time of injury ☐ am ☐ pm	5. Time employee began work on date of injury ☐ am ☐ pm			
6. EMPLOYEE Name (last, first, middle)		7. Gender ☐ M ☐ F	8. Marital Status ☐ Married ☐ Unmarried		
9. Home address		10. Home phone #	11. Date of birth		
City	State Zip Code	12. Occupation	13. Regular department	14. Date hired	
15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week	19. Employment Status ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer	
20. Weekly value of:	Meals	Lodging	2nd Income	21. Apprentice ☐ Yes ☐ No	

22. **Tell us how the injury occurred and what the employee was doing before the incident (give details).** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	**24. What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No If no, indicate name and address of place of occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI
	28. Date employer notified of injury	29. Date employer notified of lost time
	30. Return to work date	31. Date of death

32. TREATING PHYSICIAN (name, address, and phone)	33. HOSPITAL/CLINIC (name and address) (if any)	34. Emergency Room Visit ☐ Yes ☐ No	
		35. Overnight in-patient ☐ Yes ☐ No	

36. **EMPLOYER** Legal name		37. EMPLOYER DBA name (if different)	
38. **Mailing** address		39. Employer FEIN	40. Unemployment ID#
City	State Zip Code	41. Employer's contact name and phone #	
42. **Physical** address (if different)		43. Witness (name and phone)	
City	State Zip Code	44. NAICS code	45. Date form completed

46. **INSURER** name **West Bend Mutual Insurance Company**		51. **CLAIMS ADMIN COMPANY** (CA) name (check one) ☒ Insurer ☐ TPA **West Bend Mutual Insurance Company** **Phone: 800-236-5004 Fax: 262-334-6378**	
47. Insured legal name		52. CA address **1900 South 18th Avenue**	
48. Policy # or self-insured certificate #		City **West Bend**	State **WI** Zip Code **53095**
49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. Claim #

MN FR01 (05/03) Copies to: Insurer, Employer, Employee, and Workers' Compensation Division (if no insurer)

GENERAL INSTRUCTIONS TO THE EMPLOYER

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. Self-insured employers have 14 days to file this form with the Department of Labor and Industry (Department). It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will forward a copy of this form** to the Department, if necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form within **seven** days of the occurrence.

Employers are required to complete this form. Each piece of information is needed to determine liability and entitlement to benefits. Failure to complete the form may result in delayed processing and possible penalties. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department's web site at www.doli.state.mn.us. Employees are not responsible for completing this form.

SEND REPORT TO INSURER IMMEDIATELY — DO NOT WAIT FOR DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS FOR COMPLETING THIS FORM

1. Item 2: OSHA Case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
2. Items 15-20: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage.
3. Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
4. Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
5. Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
6. Item 28: Fill in the date you first became aware of the injury or illness.
7. Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
8. Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and notify your insurer if the employee misses time due to this injury after that date.
9. Item 39: Fill in your Federal Employment ID number (FEIN). For information on this number, see www.firstgov.gov and click on Employer ID Number under Business.
10. Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code which are both assigned by the Department of Economic Security (651-296-6141).
11. Items 46-54: Your insurer or claims administrator will complete this information.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR SELF-INSURED EMPLOYER

The following data elements must be completed on this form prior to filing with the Department of Labor and Industry: employee's name and social security number; date of injury; and the names of the employer and insurer. If any of this information is missing, the First Report will be rejected and returned to you (per Minn. Stat. § 176.275). Providing the name of the third party administrator does not meet the statutory requirement to provide the name of the insurer. NOTE: If the claim does not involve lost time beyond the waiting period or potential PPD, the form does **NOT** need to be filed with the Department.

1. Item 46: Fill in the name of the insurance company. If the employer is self-insured, indicate the name of the licensed or public self-insured company or group.
2. Items 47-48: Fill in the legal name of the employer who purchased the policy from the insurer (named in Item 46) and the policy number. If the employer is licensed to self-insure, fill in the certificate number.
3. Item 49: Fill in the insurer's Federal Employment ID number (FEIN) number.
4. Item 51: Fill in the name and address of the company administering the claim (either the insurer or third party administrator). Be sure to mark either the "Insurer" or "TPA" box.
5. Item 53-54: Fill in the claims administrator's FEIN and claim number.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/ Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

SUPERVISOR'S INCIDENT REPORT

☐ Injury (work related) ☐ Illness (work related)

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 ☐Estimated Date of Return Mo. Day Yr.

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

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

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.