Employee
Incident/Accident Reporting Directions

1. Employee notifies Supervisor ASAP. Supervisor begins filling out accident report. The accident must be reported within 48 hours, to be considered for Worker's Compensation.

2. If it is life threatening call 911.

3. Each form is filled out by the designated personnel:

a. *Employee*-Report of Injury (Read and sign Section 52.7 Medical Care and Examination for Claims)

b. *Supervisor*- Report of Injury (bottom half)

4. Once completed fax to Human Resource/Occupational Health at 715-253-2432.

5. If the employee may need medical attention during business hours please call Occupational Health.

Peggy Benes, RN
Occupational Health Nurse
Office: 715-787-2547

Joleen Kroening
Occupational Health Assistant
Office: 715-793-5105

PERSONAL INJURY REPORT FORM

Please type or print (use pen) Please COMPLETE answers to all questions within 48 hours

SECTION 1: Personal Information. To be completed by injured employee.

Name_____Age_____Sex___Home Phone_____
Address_____City_____State_____Zip_____
Job Title_____Department_____
Date Employed___-___-___ Hours worked per Day___Week___Married___Single___

SECTION 2: Details of accident. To be completed by injured employee.

Place of accident_____On Employer's Premises Yes__No__
Date of accident_____Time of accident_____
Did the injury result in disability beyond day of accident? Yes__No__If yes last date worked__-__-
What were you doing?_____
_____
How did the accident occur?_____
_____
What machine, tool, substance or object was most closely connected with the accident? _____
_____
Witnesses_____
Dept. or Address_____Phone_____

Injury Received_____
Treatment Rendered_____
By Whom (Name)_____
(Address)_____Phone_____

Person Injured Signature_____Date Signed_____

SECTION 3: To be completed by the immediate supervisor.

Do you agree with the above information? Yes_____ No_____
If "no", please attach your statement.
Did employee return to work? Yes__No__If yes give date__-__-
Did employee lose time? Yes_____ No_____
If yes, how much time? Days_____ Hours_____
List the dates absent due to accident_____

Was there any unsafe act? Yes_____ No_____
If yes, explain_____

Was there any unsafe condition? Yes_____ No_____
If yes, explain_____

Recommendations_____
_____

Signature of Supervisor_____Date Signed_____

RE: Incident/Accident at work

Dear Employee,

The Occupational Health Department works as an employee advocate improving and maintaining employee health and safety. We assist in work and non-work related health issues by providing a communication link between, employer, and health professionals. We follow up with incident and accident reports, work absence, and worker's compensation cases.

We thank you for reporting your incident. We are concerned about your health and would like to help you in any way we can. If this is an emergency after business hours, please see an emergency physician. We ask that you bring a slip to Human Resources for work limitation purposes, and follow-up with Occupational Health. If this incident occurred during business hours, you must contact Occupational Health if a doctor's visit may be necessary. Also, we would like to explain the following. You have 30 days from the reported date to see Occupational Health about any incident reported. We will assist you with first aid care, preventive measures, or professional treatment if necessary. **As a reminder, you must see Occupational Health before making a doctor's appointment.**

If you have no further incident/accident complaints, we hope you will recover. We extend our prevention services, which include blood pressure and blood sugar checks at your request. We are available Monday through Friday 8:00am-4:30pm, except Tribal holidays. Please contact us if you have any questions.

Best wishes,

Peggy Benes, RN
Occupational Health Nurse
Office: 715-787-2547

Joleen Kroening
Occupational Health Assistant
Office: 715-793-5105

I, _____acknowledge I must contact Occupational Health before receiving any further medical care, and I understand any other doctor's visits, besides emergency care, will result in unpaid claims.

Signature of Employee:_____ Date:_____ Time:_____

Signature of Witness:_____Date:_____ Time:_____

1. Fax form to Occupational Health immediately at 715-253-2432.
2. Attach copy of this form to incident report form.
3. Give a copy of this form to them employee.

☐ Employee will or has received emergency care.

Section 52.7 Medical Care and Examination for Claims

(A) Employer Directed Medical. Employer shall furnish reasonable medical services and supplies to treat injured workers, but the employer may designate the medical care providers from whom the worker shall seek treatment for injuries under this Ordinance.

(1) The treatment must be offered promptly and be reasonably suited to treat the injury without undue inconvenience to the worker.

(2) If a worker obtains a written statement indicating the employer's prior approval of treatments by a non-designated provider, such medical services are covered under this Ordinance.

(3) If a worker is dissatisfied with the medical care offered by the designated providers, the worker shall submit a written statement to the employer indicating this dissatisfaction and the reasons for it.

(a) Based on this statement, the worker and employer may agree that a worker shall be permitted to seek alternative treatments or care providers.

(b) If the worker and the employer cannot agree as to alternative care, the worker may receive a second opinion by a care provider of the worker's choice.

(c) The worker must receive the employer's prior approval before receiving any treatments from the care provider chosen by worker. If prior approval is not obtained, the employer is not responsible for any expense except the initial evaluation.

(d) Other care providers used by the worker may confer with and obtain information on the worker's condition from the employer-retained physician.

(B) Reasonable Examination. Whenever a worker makes a claim for compensation, the worker shall submit to reasonable, additional examinations by physicians, chiropractors, psychologists, podiatrists, or vocational experts that are provided and paid for by the employer or insurer upon written request of that party.

(1) An employer or insurer who requests such as examination shall pay the worker all necessary expenses, including transportation expenses.

(2) The worker is entitled to have a doctor that is selected by and paid by the worker present at the examination. The worker may also request and receive a copy of all reports of the examination.

(3) Independent Medical Examination.

(a) If either party disagrees with the treating provider's determination as the worker's level of disability for the purposes of compensation, an independent medical examination ("IME") can be requested.

(b) The IME will be provided by an independent provider, such as through Medical Evaluations, Inc., and will be paid for by the insurer.

(c) If the disability rating from the IME differs from the one from the treating provider, the two ratings shall be averaged and the compensation shall be based on this average.

(C) Refusal. If the worker, after a written request of the employer or insurer, refuses to submit to or in any way obstructs medical examinations, treatment, or rehabilitation (other than surgery that may endanger life or limb), the worker's right to begin or maintain any proceeding to receive worker's compensation is suspended, unless it is shown that the request is unreasonable.

(1) A worker who fails to comply with reasonable restrictions identified by his or her health care provider will be viewed as obstructing the treatment process. The worker will not be eligible for further worker's compensation benefits; provided that the worker has received notice of the

restrictions and there is documented evidence that a worker has engaged in activities in violation of these restrictions on two (2) or more occasions.

(D) Testimony. Any physician, chiropractor, psychologist, podiatrist or vocational expert who is present at any examination under subsection (B) or attended to a worker for any condition or complaint reasonably related to the condition for which the worker claims compensation:

(1) May be required to testify as to the results of their examination.

(2) May be required to furnish information and reports, relative to the claim, to the worker, employer or insurer.

(E) Privilege Waived. A worker, who reports an injury alleged to be work-related or files an application for a hearing, waives all doctor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the worker claims compensation. Any physician, chiropractor, psychologist, podiatrist, dentist, hospital, or health provider shall, within reasonable time after written request, provide the worker, employer, or insurer with any information or written material reasonably related to any injury for which the worker claims compensation.

(F) Medical Excuse from Work. To receive leave from work and benefits for lost wages under this Ordinance, a worker must provide his or her employer with a written excuse from an authorized health care provider that excuses the worker from reporting to work. If the worker is released for work in a restricted capacity, the worker shall provide his or her employer, with a written excuse from an authorized health care provider that describes the worker's restrictions. A copy of the written excuse must be provided to the employer the next work day after the appointment.

If you have any questions please contact Rene Montez.

Rene Montez
Mohican Nation Insurance
715-793-4952 phone
715-793-4380 fax

rene.montez@mohican-nsn.gov

I,_____ have read and received a copy of **Section 52.7 Medical Care and Examination for Claims**. I also acknowledge that if I have any questions regarding **Section 52.7 Medical Care and Examination for Claims** that I am to contact Rene Montez.

Print Name (Employee): _____

Signature (Employee): _____

Date of Birth: _____

Phone Number: _____

Date: _____

Print Name (Witness): _____

Signature (Witness): _____