Supervisor's Guide to Managing On-the-Job Injuries

Employee Responsibilities:

- Employee reports injury to employer/supervisor and seeks treatment from a BWC-certified medical provider (All providers in 1-888-OHIOCOMP network are BWC-certified).
- Employee identifies 1-888-OHIOCOMP as his/her MCO and shows identification card, if available.

Supervisor Action:

Step 1: Verify employee has received medical treatment.

Step 2: Verify that the location of the accident is safe and secure. Protect the site as necessary.

Step 3: The employee and/or supervisor fill out the "Initial Injury Report Form".

Step 4: Supervisor will perform an accident investigation as required and complete the "Supervisor Investigation Report". All witnesses to the accident will need to complete the "Witness Statement Form". Submit both forms to Jonette Jackson.

Step 5: Forward all forms to Jonette Jackson, County Risk Manager.

Step 6: The employee will return to work in one of these scenarios. Take appropriate action as noted:

1. The employee returns immediately from the hospital or clinic to the department. Notify Jonette Jackson of the return and especially of any restrictions.
    a. Send the Jonette Jackson the physician paperwork received from the employee immediately.
    b. Fill out "Supervisor Report of Return to Work", and send to Jonette Jackson immediately.
2. The employee reports off for a period more than one day.
    a. Request physician paperwork from the employee.
    b. Notify Jonette Jackson immediately. Send paperwork immediately when received. Note restrictions.
    c. Coordinate with Jonette Jackson for the future return to work.
    d. Begin planning for the return to work with the "Return to Work Plan" Form with coordination with Jonette Jackson.

Step 7: Upon the return to work, or at your next conversation with the injured worker while off work, request that the employee contact Jonette Jackson, County Risk Manager regarding the Sick Leave Option or Wage Continuation forms.

Step 8: Jonette Jackson will expedite the FROI and Claim Certification

General Action: Notify Jonette Jackson of any changes in the duties of the injured worker and send any paperwork received to her immediately.

Jonette Jackson
Phone: 440-329-5227 Fax: 440-329-5291

EMPLOYEE INCIDENT/ACCIDENT REPORT

*** To Be Completed by Injured Employee ***

Name: _____ Social Sec. No._____

Home Address: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

City/State/Zip: _____ Telephone: ( ) _____

Title/Position: _____ Department: _____

Accident Location: _____

Date of Injury or onset of symptoms: _____ Time: _____ ☐ am ☐ pm

Described what caused the injury/symptoms, what you were doing just before the incident, and what you did after the incident (if you need more space, write on the back of this form). **Be specific-name any objects or substances involved:** _____

_____

_____

Were you performing regular duties at the time of accident? ☐ Yes ☐ No

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who? _____

Did you report this incident to anyone? ☐ Yes ☐ No If no, why not? _____

If yes, to whom did you report it?:_____ Title/Position:_____ When: _____

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger**):**

_____

_____

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull):

_____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe: _____

Provided by: _____

_____

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?: _____

Where?: _____ If treatment was not sought immediately, explain why?: _____

_____

Did injury result in Employee fatality? ☐ Yes ☐ No

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury?: _____ By whom or where?:_____

Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury: _____

_____

Medical Release **- Under current Workers' Compensation Law, the employer is entitled to a signed medical release.** I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print): _____

Employee Signature: _____ **Date (required):** _____

EMPLOYEE INCIDENT / ACCIDENT REPORT

BACK INJURY REPORT

*** To Be Completed When a Back Injury is Reported by the Injured Employee***

Name: _____ Social Sec. No._____

Home Address: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

City/State/Zip: _____ Telephone: ( ) _____

Title/Position: _____ Department: _____

What part of your back hurts now? _____

When did you first notice this back pain? Date: _____ Time: _____ ☐ am ☐ pm

What were you doing at that time (explain in detail)? _____

_____

_____

If you were lifting an object, what was it and how heavy? _____

_____

_____

What did you feel? _____

What was the length of time between the injury and your disability, if any? _____

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who? _____

Did you report or mention this injury to anyone? ☐ Yes ☐ No If yes, who? _____ When? _____

Did you ever have a back injury before? ☐ Yes ☐ No If yes, when? _____

What part of your back? _____

Were you ever treated by a doctor? ☐ Yes ☐ No If so, when? _____

Has it given you further trouble since then? _____

Have you ever received or filed for compensation because of a back injury? ☐ Yes ☐ No

Any other injury? ☐ Yes ☐ No If yes, list Bureau of Workers' Compensation claim number(s): _____

_____

Medical Release **- Under current Workers' Compensation Law, the employer is entitled to a signed medical release.** I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print): _____

Employee Signature: _____ **Date (required):** _____

SUPERVISOR'S INVESTIGATION REPORT

Employee Name: _____ **Date of Injury:** _____

Was an investigation completed concerning the circumstances of this injury? ☐ **Yes** ☐ **No**

Were there any witnesses to this injury? ☐ **Yes** ☐ **No**
If yes, witness statements should be attached.

Was the injury a result of horseplay, under the influence of drugs, or purposely self-inflicted? ☐ **Yes** ☐ **No**
If yes, please specify:

_____
_____

Has there been any recent disciplinary action taken against this employee? ☐ **Yes** ☐ **No**
If so, please describe:

_____
_____

Has the employee missed any work previously due to similar industrial or non-industrial conditions? ☐ **Yes** ☐ **No**
If so, when? _____

Has the employee submitted medical documentation for the injury? If so, please attach. ☐ **Yes** ☐ **No**

If known, please provide us with the name, address and telephone number of the attending physician:

_____
_____
_____

Has the employee returned to work? ☐ **Yes** ☐ **No**
Last Day worked _____ Returned to work _____

If not, what is the current estimated date of return? _____

With the information you have, would you recommend the claim be accepted? ☐ **Yes** ☐ **No**
If no, why? _____

_____ _____
Supervisor Signature Date

_____ _____
Workers' Compensation Coordinator Signature Date

**Please attach completed incident reports, witness statements and any accumulated medical bills and information. Additional comments may be noted on the reverse side.

STATEMENT OF WITNESS TO ACCIDENT

I. INCIDENT INDENTIFICATION INFORMATION

Name of employee alleging incident: _____ Shift: _____

Title/Position: _____ Department: _____

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your Name: _____ Your Title/Position:_____

Your Address: _____ Your Phone Number: ( ) _____

_____

Did you see an accident involving the above employee: ☐ Yes ☐ No

If not, how did you learn about the accident? _____

_____

If you did see an accident occur?: Date of accident: _____

Time of accident: _____ ☐ am ☐ pm

Describe what you saw: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Your Signature **Please Print Your Name** **Date**