INSTRUCTIONS

SOFTWARE REQUIREMENTS

To view, complete, and print this application, you will need Adobe Reader or Adobe Acrobat software. This product is available for free download by visiting http://www.adobe.com/products/reader. The Adobe Acrobat product is a paid product. The program and associated licenses can be purchased at http://www.adobe.com/products/acrobat.

PDF CONTENTS

- PDF Instructions (1 page)
- First Notification of Injury Form (2 pages) // **IMPORTANT: Calling the County Mutual Care Line will eliminate the need to complete the Employee First Notification of Injury.**
- Physician's Return to Work Recommendations Record (1 page)
- Release of Medical Records Authorization (1 page)

COMPLETING THE FORMS ELECTRONICALLY

1. Open the PDF file
2. Click 'Save As' to save a new specific copy of the file. Not doing so will cause your master copy to overwrite any previous versions, or cause your file to be deposited into your Temporary folder.**
3. To enter text: Click your cursor over the designated field, your text cursor will display. Begin typing information into the field. Some fields will require information to be explained in detail- these fields are formatted to fit text on multiple lines. Text in these fields will get progressively smaller and automatically start a new line.
4. Check Boxes: Some questions will require a 'YES' or 'NO' answer or ask you to check a specific reply. Click the box containing your desired response, and a blue check mark will appear.
5. Once completed, save your file and print the form. Please sign.

**The ability to save individual copies of forms is only available with Adobe Acrobat. Adobe Reader users are required to print their records and scan them for digital storage.

IMPORTANT

- **THE 'FIRST NOTIFICATION OF INJURY' DOCUMENT IS TO BE FILLED OUT BY BOTH THE INJURED EMPLOYEE'S SUPERVISOR (1ST PAGE) AND THE INJURED EMPLOYEE (2ND PAGE).**
- **THE 'PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD' DOCUMENT IS TO BE FILLED OUT BY THE INJURED EMPLOYEE'S ATTENDING PHYSICIAN, AND NOT A NURSE OR PHYSICIAN'S ASSISTANT.**

WISCONSIN county MUTUAL

Contact Information

Wisconsin County Mutual Insurance Corporation
PO Box 1390, Brookfield, WI 53008-1390
Local: 262.771.0271 **Fax**: 866.662.0908

Medical Bills

Email: mailcenter@charlestaylor.com

WORKER'S COMPENSATION

FIRST NOTIFICATION OF INJURY FORM

TO BE COMPLETED BY THE SUPERVISOR

SUPERVISOR'S REPORT

Injured Person: _____ Date: _____ CHECK ONE ☐ EMPLOYEE ☐ VISITOR ☐ VOLUNTEER

Name and position of Person Preparing the Report: _____

Department: _____ Supervisor's Phone Number: _____

Date of Injury: _____ Time of Injury: _____ ☐ A.M. ☐ P.M. Left Work? (CLICK) YES NO

Address of Accident: _____

What was the employee doing when injured? Be specific. Please name any equipment used.

How did the accident occur?

How long has the employee been on the job? _____ Days _____ Months _____ Years

What safety equipment is required on the job for the work being performed?

Was the employee using all required safety equipment? YES NO

If no, which specific personal protective equipment was not used and why?

Does an unsafe condition exist that contributed to the cause? YES NO

If yes, what is the condition?

How could this accident have been prevented?

CORRECTIVE ACTION TAKEN BY SUPERVISOR? (CLICK)	YES	NO
Reinstruction of person(s) involved?	YES	NO
Equipment repair/replacement?	YES	NO
Improved Personal Protective Equipment (PPE)?	YES	NO
Reduced congestion?	YES	NO
Improved design/instruction?	YES	NO
Discipline of person(s) involved?	YES	NO

DATE: _____

Other: _____

In detail, please explain action taken to prevent recurrence:

TO BE COMPLETED BY THE INJURED EMPLOYEE, OR REPORTED THROUGH CARE LINE

EMPLOYEE INFORMATION

Name: | SSN: | GENDER M F | Home Phone:

Address: | City: | State: | ZIP:

Birthdate

EMPLOYMENT HISTORY

Occupation: | Department: | Date Hired:

ACCIDENT INFORMATION

Date of Injury: | Time of Injury: | Date Reported:

Name of individual the injury was reported to:

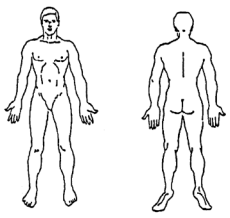
In your own words, explain in detail what you were doing immediately before the accident and how the accident occurred:

Witness? | Did/Will you seek medical treatment? YES NO

If yes, please provide physician contact information:

Clinic:
Physician:
Address:
Phone:

Indicate on the diagram the location of the injury:



Describe Symptoms:

I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

DATE: | SIGNATURE:

EMPLOYER SECTION:

PLEASE CHECK ONE:

Employee Has Not Missed Time From Work:

Employee Is Off Work:

IF EMPLOYEE IS OFF WORK, PLEASE INDICATE REASON

Authorized Off Work:

Work Restrictions:

PLEASE SUBMIT REPORT TO:

Name
Phone
Fax

PLEASE BE SURE TO ATTACH A COPY OF THE PHYSICIAN'S RETURN TO WORK REPORT IF AVAILABLE FAX REPORT TO COUNTY MUTUAL AT 866.662.0908 WITHIN 24 HOURS

Supervisor or HR Representative: | Phone:

WORKER'S COMPENSATION

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Employer Name: _____

Claim Number: _____

Patient Name: _____ Date of Injury: _____

TO BE COMPLETED BY **ATTENDING PHYSICIAN** - PLEASE CHECK

Diagnosis / Condition Explanation: _____

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

1. ☐ **Recommend his/her return to work with NO LIMITATIONS on: _____.**
(DATE)

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

☐ **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 involved 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 of when it involved 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 25 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, the 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 or 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
Bend	☐	☐	☐
Squat	☐	☐	☐
Climb	☐	☐	☐
Twist	☐	☐	☐
Reach	☐	☐	☐

Other instructions and/or limitation including prescribed medications: _____

THESE RESTRICTIONS ARE IN EFFECT UNTIL: _____ OR UNTIL THE PATIENT IS RE-EVALUATED ON: _____.
(DATE) (DATE)

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

Name of Provider: _____ Date: _____

Physician: _____

Physician's Signature: _____

WISCONSIN county MUTUAL

Wisconsin County Mutual Insurance Corporation
PO Box 1390, Brookfield, WI 53008-1390
Local: 262.771.0271 **Fax**: 866.662.0908 **Email**: mailcenter@charlestaylor.com

By law, all health care providers must provide to any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time-consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury.

Health Care Provider Name and Address		
Patient (Employee) Name	Employer Name	
Patient Social Security Number	Patient Birth Date	WC Claim No.

The patient named above hereby authorizes the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment and evaluation to:

Name and Address of Party Authorized to Receive Protected Information
Wisconsin County Mutual Insurance Corporation (c/o Charles Taylor)
PO Box 1390, Brookfield, WI 53008-1390
,

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes *all* records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

Physical Only. Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited Wis. Stat. §§ 51.30, 146.025, 146.81 and 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 and 45 C.F.R. § 164.508.

In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by a written request to the party authorized above to receive information, except that the party authorized above to receive such information may rely upon any personal health information received before the revocation of this authorization. And by notifying the disclosing medical records/health information department in writing.
- I may obtain a copy of the disclosed records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy copy shall be as valid as the original.

Patient Signature (or Person Authorized to Sign for Patient):	Date:

WITNESS STATEMENT

You were listed as a Witness to a work-related injury. Please complete this form and return within 24 hours to your supervisor.

Name of Injured Person:

Name and Position of Witness:

Date of Injury: Time of Injury A.M. P.M. Shift:

Accident Location:

Did you see the incident occur? YES NO

Were you present at the time of the incident? YES NO

Describe what the injured employee was doing immediately before the incident and how the incident occurred:

Did you see the injured employee wearing or using safety equipment at the time of the incident? YES NO

If yes, what safety equipment was the employee using?

I HAVE CAREFULLY REVIEWED THE INFORMATION CONTAINED IN THIS WITNESS STATEMENT. TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE AND ACCURATE STATEMENT OF RECOLLECTION OF THE EVENTS.

Signature of Witness: Date: