

Associate Incident Statement

Name: _____ Associate ID: _____

Date of Incident: _____ Time of Incident: _____ AM/PM

Location: _____

Date Reported to Supervisor: _____ Supervisor Name: _____

Please answer, in detail, the following questions (Use back of page if needed):

What happened? _____

How did it happen? _____

Witness(s)? (list names): _____

Describe the nature of your injury (include all body parts involved): _____

What, if any, treatment was required?: _____

Where was treatment obtained?: _____

What corrective action(s) would you recommend to prevent recurrence? _____

Signature of Associate: _____ Date: _____



If so was incident logged on OSHA 300?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Was CareWorks contacted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is injured worker a candidate for transitional work program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Witness Statement(s) Obtained?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
List names of witnesses: _____			
How could this incident have been prevented? _____			
Actions taken to prevent reoccurrence: _____			
E. First Aid given. This section to be completed for all incidents.			
First Aid Administered: _____			
F. Further care. This section to be completed for all incidents.			
<input type="checkbox"/> None	<input type="checkbox"/> Spouse/relative took home		
<input type="checkbox"/> Transported by ambulance to: _____	<input type="checkbox"/> Saw personal physician/dentist		
<input type="checkbox"/> Transported by management to: _____	<input type="checkbox"/> Other, specify: _____		
G. Additional Remarks. This section to be completed for all incidents.			

H. 30 day follow-up on incident corrective actions.			

Person reporting: _____ Date Reporting: _____

Associate: _____ Supervisor/Manager: _____

Send Copies To:

All Incidents: Workers' Compensation/Safety Process Coordinator (Original), Supervisor/Manager (1)



Witness Incident Statement

Name: _____ Employee ID: _____

Date of Incident: _____ Time of incident: _____ AM/PM

Location: _____

Name of injured associate(s): _____

Please answer, in detail, the following questions (Use back of page if needed):

What happened as observed? _____

What did you actually **SEE**? _____

Describe the nature of the associates's injury as observed: _____

What corrective action(s) would you recommend to prevent recurrence? _____

Signature of Witness: _____ Date: _____





RISKCONTROL360

Incident Document Checklist/Action Items

- Did the Associate follow the Incident Reporting Policy? Incident number created
- Copy of First Report of Injury (FROI) in our file & sent to **MCO**
- Initial contact with MCO to alert them of the claim & verify the information has been entered in **BWC**
- MEDCO 14 on file (Return to work, restrictions, off work, healthcare providers' name, and address of healthcare facility). A new Medco 14 should be requested after the last one on file expires. **(Copy MCO)**
- Release to Full Duty on file (if not part of the MEDCO 14) **(Copy to MCO)**
- Healthcare provider notes which outline the injury or illness, treatment, discharge notes, prescriptions, prognosis, etc. **(Copy MCO)**
- Verification that drug test was performed
- Incident Investigation Report completed
- Corrective actions with primary person responsible & estimated completion date (track to completion)
- Coaching, counseling, or disciplinary action (put in Associate Relations folder, not here)
- Decision was made on certifying or rejecting the claim **(TPA if Rejected, MCO if Certified)**
- Initial contact with **TPA** if any of the following apply:
 - Associate will miss more than 7 calendar days of work
 - Company is considering rejecting the validity of the claim
 - The injured worker is not your employee
 - The injured worker hasn't been released to full duty
- Decision was made if MD work is available & sent copy of MD/FD job description to **MCO & TPA**
- A MD job offer was sent via certified mail as soon as the Associate is released to return to LD work
- Decision was made on paying Salary Continuation or having the BWC pay TT compensation
 - If paying Salary Continuation (IW will miss 8 or more days): Wage sheet filled out (wages needed for one year prior to date of injury) & sent to **BWC & TPA** (TT = Temporary Total)
 - If BWC will pay TT compensation (IW will miss 8 or more days): wages submitted to **BWC**
- Keeping the **MCO, TPA, & BWC** up-to-date on the progress
- Copies of any documents from **BWC, MCO, or TPA** and decisions on appeals
- Supporting documents such as witness statements & supervisor notes collected **(copy to TPA)**
- Contact with Associate, Supervisor, **MCO, TPA & BWC** (see Contact Sheet Log)
- OSHA Recordability determination (Medical Only, Restricted Activity, Lost Time)
- OSHA 300 log filled out and/or updated

**THE BOLDING SIGNIFIES WHO TO CONTACT WITH QUESTIONS OR GIVE INFORMATION TO:
MCO = Managed Care Organization, TPA = Third Party Administrator, MD = Modified Duty, FD = Full Duty, IW = Injured Worker**

- ✓ It is critical that we have a complete history of treatment and dates from the beginning of the incident to the release to full duty.
- ✓ During initial contact with the MCO verify that the healthcare provider has entered the information to start the claim. If they have not, we must enter the information.
- ✓ We must follow the treatment plan outlined by the healthcare provider especially in regards to restrictions. If something is not clear then we contact the healthcare provider or MCO for clarification. If the healthcare provider returns the Associate to work then the Associate must return or obtain revised documents from the healthcare provider. They are administratively absent until they do so.
- ✓ Workers Compensation lost time is after 7 days away from work, but OSHA lost time is any day after the date of injury regardless of salary continuation.