



When replying, refer to: Customer Number
 Policy Number
 Policy Period

Dear Insured:

SUBJECT: WORKERS' COMPENSATION CLAIM INFORMATION

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

WB 602 D 03 07

WORKERS' COMPENSATION REPORTING TIPS

– ATTENTION – YOU MAY BE FINED IF YOU DO NOT REPORT ON-THE-JOB INJURIES ON TIME

You must complete an Employer's First Report of Injury IMMEDIATELY after an on-the-job injury occurs and forward the report to your claims administrator. **You may be fined if you do not submit the report on time.**

Send, fax, call, or e-mail the initial loss report immediately, even if you do not have all the information about the injury.

- Do not wait for medical bills.
- Do not withhold the loss report because you believe the claim is questionable. Reporting a loss is not an admission of liability.
- Be sure to include the policy number on all correspondence.

Please mail, fax, call, or e-mail the report to:

West Bend Mutual Insurance Company Claims:

All States

Workers' Compensation Claims Department
West Bend Mutual Insurance Company
1900 S. 18th Avenue
West Bend, WI 53095
Phone: 877-922-5246
FAX: 888-926-9299 or 262-334-6378
e-mail: directconnect@wbmi.com

General Questions:

Phone: 800-236-5004 or 334-6430
e-mail: wccentral@wbmi.com

NSI Claims:

Workers' Compensation Claims Department
8401 Greenway Blvd., Ste 1100
Middleton, WI 53562
Phone: 800-760-9250
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
- Right forearm
- Upper right leg
- 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
- They hurt their back lifting product
- Lifting equipment

Avoid jargon or trade names for equipment. Explain precisely what they were doing.

- Lifting an air conditioner
- Pushing a cart
- Carrying magazines
- 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
- Fracture
- Bruise
- 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).

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Department of Workforce Development
Worker's Compensation Division
 201 E. Washington Ave., Rm. C100
 P.O. Box 7901
 Madison, WI 53707-7901
 Imaging Server Fax: (608) 260-2503
 Telephone: (608) 266-1340
<http://www.dwd.wisconsin.gov/wc>
 e-mail: DWDDWC@dwd.wisconsin.gov

Fatal Injuries: Employers subject to ch. 102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to the Imaging Fax Server number on this form.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m) Wisconsin Statutes].

(Please read the instructions on Page 2 for completing this form)

EMPLOYEE	Employee Name (First, Middle, Last)			Social Security Number		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Employee Home Telephone No. () -		
	Employee Street Address				City		State		Zip Code -	
	Birthdate		Date of Hire		County and State Where Accident or Exposure Occurred?					
	Employer Name			WI Unemployment Ins. Acct No.		Self-Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Nature of Business (Specific Product)		
EMPLOYER	Employer Mailing Address				City		State		Zip Code -	
	Name of Worker's Compensation Insurance Co. or Self-Insured Employer West Bend Mutual Insurance Company, 1900 S. 18th Avenue, West Bend, WI 53095 Fax: 262-334-6378				Insurer FEIN 39-0698170					
	Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer								TPA FEIN -	
	Wage at Time of Injury \$		Specify per hr., wk., mo., yr., etc. Per:		In Addition to Wages, Check Box(es) if Employee Received:		<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Tips		No. of Meals/wk. No. of Days/wk Avg. Weekly Amt. \$	
WAGE INFORMATION	Is Worker Paid for Overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, After How Many Hours of Work Per Week?									
	For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.									
	No. of Weeks:		Gross Amount Excluding Tips: \$				If Piece-Work, No. of Hrs. Excluding Overtime:			
				Start Time		Hours Per Day		Hours Per Week		Days Per Week
	Employee's Usual Work Schedule When Injured:			: <input type="checkbox"/> AM <input type="checkbox"/> PM						
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:										
Part-Time Employment Information:		Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?				Number of Full-Time Employees Doing The Same Type Of Work:				
Injury Date		Time of Injury : AM : PM		Last Day Worked		Date Employer Notified		<input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return		
Did Injury Cause Death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Death		Was This a Lost Time or Other Compensable Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did Injury Occur Because of: <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Failure to Use Safety Devices <input type="checkbox"/> Failure to Obey Rules				
Was Employee Treated in an Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No Was Employee Hospitalized Overnight as an In-Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Name and Address of Treating Practitioner and Hospital: Case Number from the OSHA Log:										
Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.										
What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)										
What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)										
Report Prepared By			Work Phone Number () -		Position			Date Signed		

WKC-12 (R. 02/2009)

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

SUPERVISOR'S INCIDENT REPORT

Injury (work related)
 Illness (work related)
 Property Damage
 Incident

Employee Name (First, Middle, Last)			Social Security Number			Sex <input type="checkbox"/> Male <input type="checkbox"/> 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.		<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work Mo. Day Yr. <input type="checkbox"/> 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. This process often reduces our medical expenses by 10-30%.

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.wbmi.com for a link to the PPO list. Click on the "Claims" tab and then on the "Work Comp Claim Kits" tab for the link to our vendor.

QUALITY MEDICAL CARE (Applicable in Indiana and Iowa only)

As your workers' compensation insurer, we share your goal of providing quality medical care to your injured workers so that they may return to the work force as soon as possible. In Indiana and Iowa, the employer and its insurance carrier have the responsibility for providing reasonable and necessary medical care when there is an injury and the ability to choose which physician or other medical practitioner that will provide the service. **In other words, it is the employer and insurance carrier who select the physician to treat an injury, not the injured employee.** If the employee refuses to accept medical services as instructed by the carrier, the right to receive compensation may be suspended during the period of refusal.

It has been our experience that one of the most effective ways to carry out our mutual responsibilities under the Indiana and Iowa Workers' Compensation Laws for an injured worker is for you, as an employer, to designate a company physician who is authorized to treat work-related injuries. This designation should be part of our internal procedure for reporting on-the-job injuries. Each employee should be instructed, particularly when first hired, on how to report an on-the-job injury and what physician is authorized for treatment. It should be made clear that except in cases of an emergency, no other medical or chiropractic care is authorized and charges incurred for those services will not be honored. Many of our employers put this policy in writing and have the employee sign and date this document.

There are many benefits to this policy. First, injured employees know exactly where to go for medical care when needed. Second, a good working relationship is established between the physician, you as an employer, and us as an insurance company. We find we get prompt answers to our questions and are able to better manage both medical costs and claims for weekly benefits. Referrals, particularly when an independent medical exam is needed, are greatly simplified. Where rehabilitation is needed, company physicians can assist our rehabilitation nurses and our vocational counselors.

We will be happy to work with you in designating a company physician and helping you implement this program. Please feel free to call the Workers' Compensation Claim Department with any questions or comments.



**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:
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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 MEDICATION(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

Voluntary and Informed Consent for Disclosure of Health Care Information

The provision of your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

**Department of Workforce Development
Worker's Compensation Division**
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
<http://dwd.wisconsin.gov/wc/>
e-mail: DWDDWC@dwd.wisconsin.gov

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.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker than if you refuse to authorize the release of medical information.

Health Care Provider Name All Providers		Street Address	
P. O. Box	City	State	Zip Code
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 West Bend Mutual Insurance Company, 1900 South 18th Avenue, West Bend, WI 53095

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.

CHECK ONE:

- A. 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 to Wis. Stat. §§ 146.81 and 146.82, and 45 C.F.R. § 164.508.

- B. Physical and Other.** Release all records, correspondence, and any other information from whatever source regarding the patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, 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 to 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.

Patient Signature (or Person Authorized to Sign for Patient) — for Option B

Patient Signature (or Person Authorized to Sign for Patient)	Date
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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.
- 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.

If you have any questions about this document, you should contact the Worker's Compensation Division at (608) 266-1340. You should not sign this document if the name of the health care provider is blank.

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
If not signed by patient, authority/designation to sign is based on the fact that the patient is <input type="checkbox"/> A minor <input type="checkbox"/> Incompetent <input type="checkbox"/> Disabled <input type="checkbox"/> Deceased <input type="checkbox"/> Other:	

JOB ANALYSIS

Name			Claim Number				
Employer			Address				
Date of Hire	Date of Injury	Job Title			Check One <input type="checkbox"/> Skilled <input type="checkbox"/> Unskilled		
Training Required to Learn Job							
Was Employee Working as a Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Number of People Supervised		Employee Worked: <input type="checkbox"/> Alone <input type="checkbox"/> Small Group (3-5) <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, Specify							
Body Movements – Amount Spent Each Day							
Sitting		Standing		Walking			
%		%		%			
Check Appropriate Column				None	Occasion-ally (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.							
<input type="checkbox"/> 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 <input type="checkbox"/> Inside ___% <input type="checkbox"/> Outside ___%		Does Employee Walk On Uneven Ground? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does Employee Work Around Moving Machinery? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does Employee Drive Automotive Equipment? <input type="checkbox"/> Yes <input type="checkbox"/> 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				
<input type="checkbox"/> Job Site Evaluation Done		<input type="checkbox"/> Narrative Discussion Only		
Name(s) of Person(s) Interviewed		Title		
Person Completing Analysis	Title		Date	

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 _____ 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 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Instructions and/or Limitations Including Prescribed Medications:

These restrictions are in effect until _____ or until patient is re-evaluated on _____
(date) (date)

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

Physician's Signature _____

Date _____

RETURN TO WORK LOG

EMPLOYEE NAME _____ SUPERVISOR _____

Date	Hours Worked		Tasks Performed	Comments Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
	In	Out				
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.