Claims Management

Office of Workers' Compensation and Claims Management



Self-Insured and Self-Administered

- Claims are handled in-house by the Claims Office
- No third-party company handling claims
- We are U of I employees
- Coverage wherever a University employee is working UIC, UIUC, Extension Offices, Peoria and Rockford, worldwide









What is Workers' Compensation?

Medical Benefits

- Doctor visits
- Prescriptions
- Physical Therapy
- Imaging studies

Wage Benefits

- Temporary total disability pay (TTD)
- TTD = 66-2/3% of average weekly wage

Permanency Settlement

- Paid at the conclusion of a claim injury resulted in permanent disability
- Approved by an arbitrator
- Permanent partial disability (PPD)

Illinois Workers' Compensation Act

Pre-established "benefit schedule" for medical bills, TTD pay, and PPD settlements

- Allows employees two choices in medical care providers
- Exclusive remedy
- No-fault coverage for injured employees

LIFE CYCLE OF A CLAIM

Injury Reported-FROI

Employee and supervisor complete their sections supervisor sends to Claims Office – workcomp@uillinois.edu



Incident vs Claim

If benefits sought, incident becomes a claim and adjuster assigned



Compensable Claim?

Adjuster investigates and accepts/denies claim notifies employee

Claim Updates



Medical records, work statuses updated after each appointment – timesheets sent to Claims Office



Benefits Paid Out



Medical and wage benefits owed are paid



Once all benefits owed are paid and/or claim settled, claim closed

Claim Closure

- Immediately report complete FROI
- Seek medical attention and provide updated work status
- Cooperate with accident investigation
- Adhere to restrictions at all times
- Participate in temporary transitional assignments as available
- Work with supervisor and payroll to get properly coded timesheets

EMPLOYEE RESPONSIBILITIES

- Complete Supervisor's FROI and submit entire report to Claims Office
- Work with payroll to ensure timesheets are being submitted to Claims
 Office
- Advise employee to submit work statuses to the department routinely
- Get employees back to work as soon as possible restricted duty or transitional assignments
- Refer to Office of Access and Equity when appropriate

DEPARTMENT REPSONSIBILITIES

FIRST REPORT OF INJURY

Employee Section

UNIVERSITY OF ILLINOIS FIRST REPORT OF INJURY/ILLNESS Home address Sex: M / F Marital Status: S / M / Sep / W / D # Children under the age of 18 *Applied for or been denied Social Security Disability Insurance (SSDI)? pYes pNo If yes, when_ "Applied for or been denied SURS benefits? :: Yes :: No If yes, when ______ "Currently on Medicare? :: Yes :: No Job Classification: □ Academic Professional □ Faculty □ Staff □ Student □ Extra Help # Years in current job _____ Previous job title ______ # Years in previous job _____ Work days scheduled per week: MTWRFSSWork hours: ______ am _ apm _ to _____ am _ apm _ Hours per week______ EMPLOYEE'S REPORT OF INJURY/ILLNESS (Attach additional sheets as needed) Exact location where accident occurred _____ If on U of I property, include name of building / address / room #_____ Amount of training on the job prior to incident _____ Working overtime when accident happened? ☐ Yes ☐ No Do you have a second job? Yes No If yes, where Body part injured Type of injury /illness_ Describe in detail what happened: Recommendation for prevention: Witnesses (list names and phone numbers): Have you been placed out of work over 3 days? □Yes □No If yes, last day worked Number of incidents in past 3 years EMPLOYEE AUTHORIZATION — Jatiest that the above information is true and correct. I authorize my treating medical provider to release appropriate medical information to the University of Illinois Office of Workers' Compensation and Claims Management (U of I') in order to determine compensability of my daim, Lunderstand that pursuant to the Health Insurance Portability and Accountability Ad ("HEPAA"), a covered entity may disclose protected health information as authorized by laws reiating to workers' compensation or similar programs, established by law, that provide benefits for work-reiated injuries or linesses without regard to fault. I understand that the medical information relating to my workers' compensation claim and received by U of I and its legal representatives does not constitute protected health information, I understand that without the first report of Injuny/liness and pertinent medical information my claim may be denied. I further Rev 6/17

Supervisor Section – P1

	mit via campus mail or elec	T OF INJURY/ILLNESS ctronically to WorkComp@uill 4 hours of incident by superv	
Employee's name		UIN #	
Employee's department		Job title	
Supervisor's name	Supervi	sor's phone #C	Campus location
Is employee on university pays	roll? □Yes □No Wage acc	ount paid from on date of acciden	nt
Is employee currently working	? ::Yes ::No If no, last day	worked	
Date of incident	_ Time of incident	Time began work	Time stopped work
Date employee reported incide	ent Incident lo	cation (street, bldg, room)	
Witnesses to incident (include			
What activity was the employe	e doing just before the incider	nt occurred? (Attach additional sh	eets as needed.)
What object or substance direct	ctly harmed the employee?		
	ctly harmed the employee?		
Body part(s) affected:		Hand □R □L	Neck 🗆
Body part(s) affected: Abdomen Ankle R L	(Check all that apply)	Hand □R □L Head □	Neck ☐ Shoulder ☐R ☐L
Body part(s) affected: Abdomen Ankle R L	(Check all that apply) Elbow R L Eye R L Face L	Head ☐ Hip ☐R ☐L	Shoulder R L Toes
What object or substance direct Body partist affected: Abdomen Antic R L Arm CR Back Back	(Check all that apply) Elbow R L Eye R L Face Finger R L	Head ☐ Hip ☐R ☐L Knee ☐R ☐L	Shoulder R L
Body partist affected: Abdomen Ankle R L Arm RR Book Chest	(Check all that apply) Blow R L Eye R L Face Finger R L Foot DR L	Head	Shoulder _R _L Toes _ Wrist _R _L
Body partist affected: Abdomen Ankle R L Arm RR Book Chest	(Check all that apply) Elbow R L Eye R L Face Finger R L	Head ☐ Hip ☐R ☐L Knee ☐R ☐L	Shoulder R L Toes
Body partis) affected: Abdomen Antile CR Ammer Back Back Chest Err CR CR	(Check all that apply) Blow R L Eye R L Face Finger R L Foot DR L	Head	Shoulder _R _L Toes _ Wrist _R _L
Body partisk affected: Abdomen Anick E Ani	(Check all that apply) Bloow R L Bye R C Face Face Foot R L Groin	Head	Shoulder _R _L Toes _ Wrist _R _L
Body partis) affected: Abdomen Anite DR Anim CR Beak Chest Cree of Injuny. Anoption Anoption	(Check all that apply) Ebow R L Ebow R L Face For R Froot R L Groin (Check all that apply)	Head Hip R L Knee R L Leg R L Lungs	Shoulder _R _L Toes _ Wrist _R _L Other
Body partis) affected: Abdonnen Ariske Sk Ariske Sk Ariske Chest Chest Time of Injury. Absorption Annuation Broise	(Check all that apply) Elbow CR L Eye R L Face L Foot R L Foot R L Foot R L Foot R L Infantation Ingestion	Head Hp ICR L Knee R L Lag R L Lungs L Laceration Over-exertion Over-exposure	Shoulder _R _L Toes _ Wrist _R _L Other
Body sart(s) affected: Abdomen Antic R Antic Bruse Bruse Bruse Bruse	(Check all that apply) Ebow R L	Head He	Shoulder _R _L Toes _ Wrist _R _L Other
Body sart(s) affected: Abdomen Antic R Antic Bruse Bruse Bruse Bruse	(Check all that apply) Elbow CR L Eye R L Face L Foot R L Foot R L Foot R L Infantation Infantation Ingestion	Head Hp ICR L Knee R L Lag R L Lungs L Laceration Over-exertion Over-exposure	Shoulder _R _L Toes _ Wrist _R _L Other
Body part(s) affected: Abdomen Ankle R L	(Check all that apply) Ebow R L	Head He	Shoulder _R _L Toes _ Wrist _R _L Other

Supervisor Section – P2

	Repetitive motion	_	_	
Electrical contact	Slip / Twist	Struck by / stru		
Explosion	Slip / Trip / Fall [Fall from eleva	tion 🗆	
Where was the employee rel Drug screen performed?			alcohol test performed?	res □No
Contributing conditions:	Con	tributing behaviors:	Preventative Action – Su	pervisor wil
Duties or tasks not clear	□As	sistive device not used	Develop / revise safety	procedures
Equipment or tool defect / fail	ure 📭	ilure to get assistance	Maintain good houseker	eping
Equipment or tool unavailable	□ Im	proper tool / equipment used	Maintain tools / equipme	ent
☐Ergonomic factors	□ln	attention to task	☐Post safety signs	
Lighting / temperature / ventil	ationLa	ck of communication	Perform job hazard anal	lysis
Procedure lacking or unclear	□Pr	ocedure not followed	☐Provide protection equip	ment
Training lacking or incomplete	. □Pr	otective equipment not worn	Remove defective equip	ment
☐Work area set-up / arrangeme	ent □Ru	shing or hurried	Schedule safety training	
Unrecognized hazard	□Ur	balanced or poor position or moti	on DOther	
⊓Other	ПО	her		
What could the employee ha	ve done to avoid	the injury? (Attach additional si		
What could the employee ha	ve done to avoid			(Attach
What could the employee ha	ve done to avoid	the injury? (Attach additional si		
What could the employee ha	ve done to avoid	the injury? (Attach additional sitrol measures that will be put in the put in	place to prevent recurrence	as needed)
What could the employee ha List any other actions that will additional sheets as needed Was disciplinary action issue Are you concerned about the	Il be taken or con	the injury? (Attach additional size in the injury? (Attach additional size in the injury? (Attach additional size in the injury? (Yes oNo if yes, explain? OYes on a temporary basis, allows the medical limitations.	place to prevent recurrence ain (Attach additional sheets ain (Attach additional sheets	as needed)
What could the employee ha List any other actions that wi additional sheets as needed Was disciplinary action issue Are you concerned about the Temporary Transitional / M meaningful, appropriate worl Department will provide trans Please explain answer	we done to avoid Il be taken or con Il do for an unsafe a validity of this cla todified Work - or cluties based on ititional /modified	the injury? (Attach additional size in the injury? (Attach additional size in the injury? (Attach additional size in the injury? (Yes oNo if yes, explain? OYes on a temporary basis, allows the medical limitations.	place to prevent recurrence ain (Attach additional sheets ain (Attach additional sheets air (Attach additional sheets the injured worker the opporture	as needed)
What could the employee ha List any other actions that wi additional sheets as needed Was disciplinary action issue Are you concerned about the Temporary Transitional / M meaningful, appropriate worl Department will provide trans Please explain answer	we done to avoid If be taken or com If be taken or com If the taken o	the injury? (Attach additional size in the injury? (Attach additional size in the injury? (Attach additional size in the injury? (Yes cNo If yes, explain? OYes cNo If yes, explain.	place to prevent recurrence ain (Attach additional sheets ain (Attach additional sheets air (Attach additional sheets the injured worker the opporture	as needed)
What could the employee ha List any other actions that wi additional sheets as needed Was disciplinary action issue Are you concerned about the Temporary Transitional // meaningful, appropriate word Department will provide tran- Please explain answer Department requests assista	we done to avoid If be taken or com If be taken or com If the taken o	the injury? (Attach additional size in the injury? (Attach additional size in the injury? (Attach additional size in the put in the injury? (Attach additional injury?) (A	place to prevent recurrence ain (Attach additional sheets ain (Attach additional sheets air (Attach additional sheets the injured worker the opporture	as needed)

FROI – UNACCEPTABLE SUPERVISOR SECTION

EMPLOYEE SECTION

SUPERVISOR SECTION – P1

1st Supervisor Version

SUPERVISOR SECTION – P2

				1st Supervisor V	le
	, *				
UNIVERSITY OF ILLINOIS					
FIRST REPORT OF INJURY/ILLNESS			SITY OF ILLINOIS		
Submit via campus mail or electronically to WorkComp@uilllinois.edu			RT OF INJURY/ILLNESS		
(To be completed by employee within 24 hours of incident)	Su		ectronically to WorkComp@uil		
EMPLOYEE INFORMATION (* Federal Government/University Required Information)		(To be completed within	24 hours of incident by superv	risor)	
Name Brand; Perry UIN# 555	Employee's name 3 Y	andi Perry	UIN# 5	55	
Home address 2 3 Main Phone # 555 5	Employee's department		Job title Claims	Cinque al col	
City Champaign State TL ZIP 6/82/					
Birth date 4-5-83 Sex: M /F Marital Status S M / Sep / W / D # Children under the age of 18			visor's phone #_5555		7
Applied for or been denied Social Security Disability Insurance (SSDI)? □Yes ®No If yes, when	Is employee on university pa	yroll? oxes □No Wage ac	count paid from on date of accide	nt 55	
Applied for or been denied SURS benefits? ©Yes pNo If yes, when *Currently on Medicare? © Yes pNo	Is employee currently working	g? ⊡Yes No If no, last da	worked 10/1/18		
	Date of incident 10/1/18	Time of incident 11 PM	Time began work 8 aw	Time stopped work 11 am)
lob Classification: Academic Professional Faculty Staff Student Extra Help			ocation (street, bldg, room)		
Date of hire 711116 Job Title Claim S Rep Department KISK	Witnesses to incident (included)		The state of the s	***************************************	Т
Years in current job_2 Previous job title Claims assoc #Years in previous job 12			ent occurred? (Attach additional sh	oate se naadad)	
Vork days scheduled per week (MTWR) S S Work hours: 8 Infinity Inf		to a meeting	- (Attach additional a	ledis as riceded.	_
EMPLOYEE'S REPORT OF INJURY/ILLNESS (Attach additional sheets as needed)	What have and O'To all to be			. t. n	_
Date of Injury/Illness 10/1/18 Time 1/ Bem Ipm Day of week Monday			ed, attach additional sheets as nee		
Date Reported 18/1/18 To Daviene			meeting and ful		_
exact location where accident occurred North Stairwell DW 3rdt 4m floor			use elevator we	as not working	-
f on U of I property, include name of building / address / room # HAB - north StairWall	50 I had to	take the sta	YS.		_
Amount of training on the job prior to incident 2 was S					
	What object or substance di	ectly harmed the employee?			
Norking overtime when accident happened?	Strarway				
Do you have a second job? Pres Tylio If yes, where					
Body part injured Khee Type of injury fillness Strain/Sprain					
Describe in detail what happened: 1 was headed to a meeting and full down	Body part(s) affected:	(Check all that apply)			
the stairs - elevator was not working J	Body parts and the	(Oneck all that apply)			
Recommendation for prevention: Install another elevator.	Abdomen	Elbow R L	Hand □R □L	Neck 🗆	
Witnesses (list names and phone numbers): Nove	Ankle R L	Eye R L	Head	Shoulder R L	
Did you receive medical treatment? Thes INo If yes, where?	Arm □R □L	Face □	Hip □R □L /	Toes □	
A STATE OF THE PARTY OF THE PAR	Back □	Finger R L	Knee R VL	Wrist R L	
Have you been placed out of work over 3 days? √2Yes □No If yes, last day worked 16/1/1/8	Chest □	Foot DR DL	Leg DR DL		
s this a recurrence or aggravation of a previously reported injury / illness? 🗆 Yes 🖾 No 💮 If yes, please explain	Ear DR DL	Groin □	Lungs	Other	
	Ear Lik Lie	Gioin	Culigs []	Other	
N 100 18 100 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Type of Injury:	(Check all that apply)			
lumber of incidents in past 3 years	Absorption	Franker C	Laceration [Other	
EMPLOYEE AUTHORIZATION - I attest that the above information is true and correct. I authorize my treating medical provider to release appropriate	Amputation	Fracture ☐ Inflammation ☐	Over-exertion	Otriei	
nedical information to the University of Illinois Office of Workers' Compensation and Claims Management ('U of I') in order to determine compensability of my					
laim. I understand that pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), a covered entity may disclose protected health information as	Bruise	Ingestion	Over-exposure		
uthorized by laws relating to workers' compensation or similar programs, established by law, that provide benefits for work-related injuries or illnesses without egerd to fault. I understand that the medical information relating to my workers' compensation claim and received by U of I and its legal representatives does not	Burn 🗌	Inhalation	Puncture		
onstitute protected health information. I understand that without the first report of injury/illness and pertinent medical information my claim may be denied. I further	Foreign Body	Irritation	Strain / Sprain 🔲		
nderstand it is unlawful to present a fraudulent claim for workers' compensation benefits and doing so may result in disciplinary action.	Type of event:	(Check all that apply)			
10/3/19	1 The Ot event.	(Onser all that apply)			
ignature of Employee Date	Body Motion / Body Position [Fall on same level	Temperature extreme ☐	Unknown	
Rev 6/17				Rev 6/17	

Caught in / under / between	Repetitive motion	Vehicle Accident [Other
Electrical contact	Slip / Twist 🗆 /	Struck by / struck	against
Explosion	Slip / Trip / Fall	Fall from elevation	
Where was the employee refe	erred for medical care?	arle occ n	ned
Drug screen performed?	es DNo	Breath ale	cohol test performed? DYes No
Contributing conditions:	Contributing b	ehaviors:	Preventative Action - Supervisor will do
Duties or tasks not clear	☐Assistive devi	ice not used	☐Develop / revise safety procedures
Equipment or tool defect / failu	re	assistance	Maintain good housekeeping
quipment or tool unavailable	elevator Improper tool	/ equipment used	☐Maintain tools / equipment
☐Ergonomic factors	☐Inattention to	task	□Post safety signs
Lighting / temperature / ventila	tionLack of comm	nunication	□Perform job hazard analysis
Procedure lacking or unclear	□Procedure no	t followed	□Provide protection equipment
☐Training lacking or incomplete	□Protective equ	uipment not worn	Remove defective equipment
□Work area set-up / arrangeme	nt Rushing or hu	urried	Schedule safety training
Unrecognized hazard	☐Unbalanced o	or poor position or motion	□Other
□Other What could the employee hav	Other re done to avoid the injury?		
What could the employee hav	e done to avoid the injury?	(Attach additional shee	
Other What could the employee hav What could the employee hav It is any other actions that will additional sheets as needed)	be taken or control measures of the control measures o	(Attach additional shee	ets as needed)
Other What could the employee hav	be taken or control measured by a control me	(Attach additional sheer res that will be put in place) If yes, explain	rts as needed) ace to prevent recurrence (Attach
Other What could the employee hav What could the employee have What could the employee have What could the employee have What disciplinary action issued Are you concerned about the	be taken or control measuring to the control m	(Attach additional sheet will be put in plants of the put in plants of t	ets as needed) ace to prevent recurrence (Attach (Attach additional sheets as needed) (Attach additional sheets as needed)
What could the employee hav List any other actions that will additional sheets as needed). Was disciplinary action issued Are you concerned about the Temporary Transitional / Mc meaningful, appropriate work Department will provide transi	be taken or control measure of for an unsafe act? eYes a validity of this claim? eYes oddfied Work - on a tempo duties based on medical lititional /modified work:	(Attach additional sheet res that will be put in plus of the put in pl	ets as needed) ace to prevent recurrence (Attach (Attach additional sheets as needed) (Attach additional sheets as needed)

Rev 6/17

FROI – ACCEPTABLE SUPERVISOR SECTION

2nd supervisor version

Rev 6/17

EMPLOYEE SECTION

SUPERVISOR SECTION – P1

SUPERVISOR SECTION – P2

1	
UNIVERSITY	
FIRST REPORT OF Submit via campus mail or electronicall	
(To be completed by employee wi	
EMPLOYEE INFORMATION (* Federal Government/University Re	
Name Brandi Perry	UIN #_555
Home address 123 MWN	Phone #_ 555 5
city Unampaign	State TL ZIP 6 8 2 1
Birth date 4-5-83 Sex: M /F Marital Status S/ M / Sep / V	
Applied for or been denied Social Security Disability Insurance (SSD	/
"Applied for or been denied SURS benefits? =Yes pNo If yes, when_	*Currently on Medicare? Yes No
Job Classification: Academic Professional - Faculty - Staff -	
Date of hire 71116 Job Title Claim S Rup	Department KI & K
Years in current job_2_ Previous job title_Claims as	#Years in previous job 12
Work days scheduled per week MTWRFS S Work hours:	om □pm to 5 □am □pm Hours per week 40
(Circle all that apply)	
MPLOYEE'S REPORT OF INJURY/ILLNESS (Attach additional	(hahaan se staads
Date of Injury/Illness 10/1/18 Time 1/	Dem ppm Day of week Monday
Date Reported 18/1/18 To Danene	
xact location where accident occurred North Stair	well blu 3rd + 4m floor
f on U of I property, include name of building / address / room # #	AB - north Stairwell
Amount of training on the job prior to incident 2 wars	
Norking overtime when accident happened? Yes	
Do you have a second job? DYes Who If ves. where	
	ype of injury /illness Strain/Sprain
Describe in detail what happened: 1 Was headed t	to a mosting and fell down
the stairs - elevator was not	- WM King)
Recommendation for prevention: INSTALL GIVILLAY &	levator. J
Vitnesses (list names and phone numbers): None	
Did you receive medical treatment? Wes No If yes, where?	
- The state of the	f yes, last day worked 16/1/18
	, , , , , , , , , , , , , , , , , , , ,
s this a recurrence or aggravation of a previously reported injury / illn	ess? □Yes NNo If yes, please explain
Number of incidents in past 3 years	
MPLOYEE AUTHORIZATION - I attest that the above information is to redical information to the University of Illinois Office of Workers' Compensation and	
laim. I understand that pursuant to the Health Insurance Portability and Accountab	ility Act ("HIPAA"), a covered entity may disclose protected health information as
uthorized by laws relating to workers' compensation or similar programs, establish	
agard to fault. I understand that the medical information relating to my workers' cor onstitute protected health information. I understand that without the first report of ir	
constitute protected health information. I understand that without the first report or in Inderstand it is unlawful to present a fraudulent claim for workers' compensation be	
Da -	1410110
ym run	10/3/18
Signature of Employee	Date

Rev 6/17

_		ORT OF INJURY/ILLNESS	
Sı		electronically to WorkComp@ui n 24 hours of incident by super	
		il 24 flours of incident by super	VISOIJ
Employee's name_BRA	INDI PERRY	UIN# 55	55
Employee's department <u>0</u>	USK	Job title CLAI m.S	SPECIALIST
Supervisor's name DAQ	LENE FRAZIER SUP	ervisor's phone #_5555	Campus location, J-UIUC
Is employee on university p	payroll? to¥es □No Wage	account paid from on date of accide	nt <u>555</u>
s employee currently worki	ing? ⊡Yes ⊕ No If no, last o	lay worked/_/_/	West-Million Committee of the Committee
Date of incident 16 11	g Time of incident 11 6	m. Time began work 8 an	Time stopped work
Date employee reported inc	cident 10/1/18 Inciden	t location (street, bldg, room) M.	Stairwell
Witnesses to incident (inclu	ide phone #) NoNE	HAT I AM AWAI	RE OF
		dent occurred? (Attach additional sl	
GOING TO G	SET LUNCH BE	EFORE A MEETI	NO
		rred, attach additional sheets as ne	
THE EMPLOYE	E TOILD ME	SHE WAS TEXT	ING AND FELL
DOWN THE S			
MANUEL .	DITTED		
1470 1211			
	firectly harmed the employee		
	firectly harmed the employee?		
HER KNEEL	HIT THE PLOC		
HER KNEE F	(Check all that apply))R	
HER KNEE L Body part(s) affected: Abdomen	(Check all that apply)	Hand 🔐 🗀	Neck
HER KNER F Body part(s) affected: Abdomen Ankle R L	(Check all that apply) Elbow DR DL Eye DR DL	Hand 📭 🗀 Head 🗇	Shoulder R L
HER KNER F BOOK part(s) affected: Abdomen Ankle R L Arm R L	(Check all that apply) Elbow □R □L Eye □R □L Face □	Hand R L Head T	Shoulder □R □L Toes □
Abdomen : Ankle : R : L Arm : R : L Back : D	(Check all that apply) Elbow R L Eye R L Face Finger R L	Hand R L Head Head Knee R SV	Shoulder R L
Abdomen Abdomen Ankle Arm Back Abdomen Arm Back Abdomen Abdomen Arm Abdomen Abdome	(Check all that apply) Elbow R L Eye R L Face C Finger R L Foot R L	Hand R L Head C Hip R L Knee R SV Leg R L	Shoulder _R _L Toes _ Wrist _R _L
Abdomen Abdomen Ankle Arm Back Abdomen Arm Back Abdomen Abdomen Arm Abdomen Abdome	(Check all that apply) Elbow R L Eye R L Face Finger R L	Hand R L Head Head Knee R SV	Shoulder □R □L Toes □
ABOV part(s) affected: Abdomen Annie Chest Chest Car Car	(Check all that apply) Elbow R L Eye R L Face C Finger R L Foot R L	Hand R L Head C Hip R L Knee R SV Leg R L	Shoulder _R _L Toes _ Wrist _R _L
HER KNEEL Lody part(s) affected: bbdomen nnkle IR Lock thest ar R vpe of Injury:	(Check all that apply) Elbow DR DL Eye DR DL Face D Finger DR DL Groin D (Check all that apply)	Hand R L Head Hip R L Knee DR ISV Leg R L Lungs	Shoulder _R _L Toes _ Wrist _R _L
HER KNEEL Lody part(s) affected: bdomen	(Check all that apply) Elbow DR DL Eye DR DL Face D Finger DR DL Groin D	Hand R L Head C Hip R L Knee R SV Leg R L	Shoulder _R _L Toes _ Wrist _R _L Other
Body part(s) affected: Abdomen Inkle R Inkle R	(Check all that apply) Elbow R L Eye R L Face Finger R L Foot R L Groin (Check all that apply) Fracture	Hand R L Head Hip R L Knee R SV Leg R L Lungs	Shoulder _R _L Toes _ Wrist _R _L Other
Body part(s) affected: Abdomen Inkle R Inkle R	(Check all that apply) Elbow R L Eye R L Face Finger R L Groin (Check all that apply) Fracture Inflammation	Hand R L Head Hip R L Knee R S Leg R L Lungs Laceration Over-exertion	ShoulderR _L Toes _ Wrist _R _L Other
HER KNEEL	(Check all that apply) Elbow R L Eye R L Face Finger R L Foot R L Groin (Check all that apply) Fracture Inflammation Ingestion	Hand R L Head C Hip R L Knee R SV Leg R L Lungs C Ver-exertion C Over-exposure	Shoulder _R _L Toes _ Wrist _R _L Other
Body part(s) affected; Abdomen Ankle R Ankle Ankle R Ankle Ankle R Ankle Ankle R Ankle Ankle R Ankle Ankle R Ankle Ankle R Ankle Ankle R Ankle R Ankle R Ankle R Ankle R	(Check all that apply) Elbow R L Eye R L Face Finger R L Foot R L Groin C (Check all that apply) Fracture Inflammation Ingestion Inhabition Irritation	Hand R L Head Hip R L Knee R SV Leg R L Lungs Laceration Over-exprisure Puncture	Shoulder _R _L Toes _ Wrist _R _L Other
Sody part(s) affected: bbdomen wm R L. sack chest sar R L. support of Injury: support of Linguistics support of Ling	(Check all that apply) Elbow DR DL Eye DR DL Face DFINGER DL Foot DR DL Groin DFINGER DL Inflammation DI Inhalation D	Hand R L Head Hip R L Knee R SV Leg R L Lungs Laceration Over-exprisure Puncture	Shoulder _R _L Toes _ Wrist _R _L Other

	petitive motion	Vehicle Accident [Other
Electrical contact Slip	p / Twist 🗆 /	Struck by / struck	against 🗆
Explosion Slip	p / Trip / Fall 🔘	Fall from elevation	
Where was the employee referred	for medical care? SH	E WENT TO	O CAPLE OCC MED
Drug screen performed? □Yes	awo	Breath all	cohol test performed? pYes pN6
Contributing conditions: Duties or tasks not clear	Contributing be		Preventative Action – Supervisor will do
☐Equipment or tool defect / failure	☐Failure to get a	ssistance	Maintain good housekeeping
DEquipment or tool unavailable			Maintain tools / equipment
DÉquipment or tool unavailable Clevetor not Work	hg Whattention to ta	isk Texting	□Post safety signs
Lighting / temperature / ventilation	Lack of commu	nication	Perform job hazard analysis
Procedure lacking or unclear	Procedure not	followed	Provide protection equipment
Training lacking or incomplete	☐Protective equi	pment not worn	Remove defective equipment
☐Work area set-up / arrangement	Rushing or hum	ried	Schedule safety training
☐Unrecognized hazard	☐Unbalanced or	poor position or motion	□Other
□Other	□Other		
What could the employee have do PALD ATTENTION OF TEXTING OF	I TO WHERE		ts as needed) 601 NG = INSTEAD
PAID ATTENTION OF TEXTING OF List any other actions that will be t additional sheets as needed) R	TO WHERE N STAIRS aken or control measure	SHE WAS	GOLNG - INSTEAD
PAID ATTENTION OF TEXTING OF List any other actions that will be t	TO WHERE N STAIRS aken or control measure	SHE WAS	GOLNG - INSTEAD
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PAID ATTENTION OF TEXTING OF List any other actions that will be t additional sheets as needed) Riscurption Was disciplinary action issued for Are you concerned about the valid Temporary Transitional / Modifi meaningful, appropriate work dutio Department will provide transitione Please explain answer DLD	A designing transitional /	ss that will be put in place. The street will be put in place. The	ace to prevent recurrence (Attach BE AWAPE OF (Attach additional sheets as needed) (Attach additional sheets as needed) ijured worker the opportunity to engage in





If in doubt, fill it out!

Why does all of this matter?

- Safety of all employees matters
- Department productivity
- TTD and PPD benefits = 49% chargeback

IT MATTERS!



HOW DO WE BRING COSTS DOWN?

- The First Report of Injury needs to be filled out timely, accurately, and completely and submitted to our office as soon as possible.
- Limit the time on TTD/bring people back to work
 - #1 contributor to indemnity costs
 - The longer the TTD, the higher the settlements
- Address safety issues through discipline

CONTACT US

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- Courtney Beasley, Claims Specialist
- Mclain Engel, Claims Specialist

THANK YOU!

