Carmel Unified School District

WORKER'S COMPENSATION

INJURY REPORT

Please have employee take the following forms with them when they seek medical treatment:

- Authorization for Treatment
- Temporary Pharmacy Card

then,

Please send all completed forms to the CUSD Worker's Compensation Coordinator as soon as possible:

Geri Simmons
clo CUSD District Office
Human Resources Department

Thank you!
Carmel Unified School District

WORKERS COMPENSATION MEDICAL AUTHORIZATION

Employer Authorization:

AthenaMed Occupational Medicine:

915 Hilby Avenue, Suite 26, Seaside, CA 93955, (831) 900-5757

Doctors on Duty: 501 Lighthouse Avenue, Monterey, CA 93940, (831) 649-0770
1513 Fremont Blvd., Seaside, CA 93955, (831) 899-1910
1212 South Main St., Salinas, CA 93901, (831) 422-7777

Pinnacle Health Care: 947 Blanco Circle, Suite A Salinas, CA 93901, (831) 422-5555

Hospital: Community Hospital of the Monterey Bay Peninsula:
23625 Holman Highway, Monterey, CA 93940, (831) 624-5311

Employer: Carmel Unified School District
4380 Carmel Valley Road, Carmel, CA 93923
P.O. Box 222700, Carmel, CA 93922

Worker's Compensation Coordinator: Geri Simmons
Human Resources Department, gsimmons@carmelunified.org, office# (831) 624-1546 x 2016 or fax# (831) 626-4052

Claims Administrator: Monterey Educational Risk Management Authority
P.O. Box 3320, Salinas, CA 93912 (831)
783-3311, Fax# (916) 781-5781

EMPLOYEE ACKNOWLEDGEMENT OF THE MEDICAL PROVIDER NETWORK

In order to provide the most timely and suitable quality medical care in the event of an injury on the job, we have instituted a Medical Provider Network for Workers' Compensation. The following procedures must be followed for all work related injuries and illnesses:

• Report promptly any work related injury to your supervisor.
• For a referral to a medical provider specialist, contact your employer or claims adjuster.
• Ensure all medical treatment is handled only through the MPN (Medical Provider Network) (above).
• Direct all questions about the level of care to the PCP (Primary Care Physician), who is the focal point for all medical treatment.
• A directory of medical care providers is available at my request through my employer.

Please sign below to indicate that you have read and understand the procedures to follow in the event of an injury and your duties under our Medical Provider Network.

Print Name ___________________________ Date ____________

Employee Signature ___________________________ Employer ____________

Employee Number ___________________________

Rev 9/2/20 gs fg
First Fill
Temporary Pharmacy Card
Making it easy to get your workers' compensation prescriptions filled.

**Employer:**
Immediately upon receiving notice of injury, fill in the information below and give it to your employee.

**Injured Employee:**
1. If you need a prescription filled for a work-related injury or illness, go to a Tmesys network pharmacy.
2. Give this page to the pharmacist.
3. The pharmacist will fill your prescription at no cost.

**Questions?**
Call 1.866.599.5426

**Necesitas ayuda en español? Llame al 1.866.599.5426**

**Pharmacist:**
1. Call the Tmesys Pharmacy Help Desk at 800.964.2531.
2. Provide the information from the card.
3. The Help Desk will provide an ID number for adjudication.

**Finding a Network Pharmacy**
Use one of these easy methods to find a network pharmacy:
- Visit your local Walgreens or Rite Aid Pharmacy
- Call us: 866.599.5426
- Use our pharmacy locator online: www.tmesys.com.
Injured worker notifies supervisor.

Supervisor / Injured worker immediately calls injury hotline.

Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.

Notice to Employer/Supervisor:
Please post copies of this poster in multiple locations within your worksite. If the injury is non-life threatening, please call Company Nurse prior to seeking treatment. Minor injuries should be reported prior to leaving the job site when possible.
COMPANY NURSE INTRODUCTION

In an effort to more effectively manage our workers' compensation claims, MERMA has implemented an injury management program called Company Nurse®. When you encounter a workplace injury, the supervisor and injured employee will call the Company Nurse® injury Hotline as soon as possible after the injury/incident occurs. After the Injury Care Coordinator records the injury and incident information, the attending nurse will provide first aid advice and direct the injured employee to an appropriate workers comp treatment site if needed. COMPANY NURSE® will handle all initial reporting of workplace injuries.

Here's how it works:

The process is simple. Just call! If an injury is not a medical emergency, the MANAGER and the EMPLOYEE will telephone COMPANY NURSE® at 1-855-602-5266 before seeking treatment. They will speak with a Registered Nurse who will assist the employee with his or her medical needs and expedite the claims processing. The nurse will talk to the manager first and then the employee to determine what kind of treatment, if any, is necessary for the employee based upon their conversation with them and the manager.

Important Hotline facts:

The COMPANY NURSE® INJURY HOTLINE is available 24 hours per day, seven days per week.

- Company Nurse® will complete the First Report of Injury form and email or fax it to our claims processing administrator.

- The Manager and/or Employee only needs to report the injury once to Company Nurse®. However, you can call back any time with changes or updates to the report if needed.

- Company Nurse® will handle all initial reporting of employee incidents.

The advantage of a medical professional assisting in directing the employee's medical treatment should result in cost savings and fewer claims if first aid can be applied. Furthermore, employees will receive instant telephonic first aid advice from a Registered Nurse, and be referred for further treatment if needed.

Your cooperation and participation is appreciated. Please do not hesitate to call your primary contact if you have any questions regarding this process.
COMPANY NURSE® INJURY REPORTING

NOTE: If life- or limb-threatening injury only, call 911!! Then report the injury/ incident after the employee is stabilized.

Step 1 | MAKE THE CALL BEFORE SEEKING TREATMENT

• Notify supervisor of the injury/incident
  • In a quiet place, employee and/or supervisor call Company Nurse at 855-602-5266
• You will be asked to provide the following information during the call:
  1. Search Code
  2. Employer name and/or worksite
  3. Employee personal information

• Possible Outcomes as a result of the Call:
  o Self-care or basic first aid, OR
  o Referral to medical facility by a Nurse - OCC Health or Urgent Care or ER

• IMPORTANT!
  o Translators are available for more than 170 different languages
  o Be prepared to write down a Call Confirmation Number

Step 2 | REPORT DISTRIBUTION AFTER THE CALL

• Report of Injury is emailed or faxed to key stakeholders at the employer
• If injured employee is referred for medical treatment, an Alert will be sent immediately to the medical provider to expect the employee at their facility

Step 3 | FOLLOW-UP CALL

• Additional Nurse Advice: Employees who were triaged by a nurse but not initially referred, are welcome to call our nurses again if injuries become worse or new symptoms develop for which they may require additional nurse advice or injury triage services and a possible referral for medical treatment.
Q. Should every workplace injury be reported to Company Nurse®?
A. Yes, every injury should be called in to Company Nurse®. CALL COMPANY NURSE® BEFORE THE EMPLOYEE LEAVES THE JOB SITE. This will provide injury information immediately to Safety and Risk Management personnel on every injury. This is a 24/7 service, including all holidays.

Q. How should an obvious emergency situation be handled?
A. In all life- or limb-threatening situations, call 911 or transport directly to the ER immediately. Call Company Nurse® with any information that you have regarding the incident once the situation has stabilized.

Q. Does Company Nurse® diagnose an injury over the telephone?
A. We do not diagnose injuries. We perform a triage process that guides the employee to the appropriate level of care for treatment based on the information obtained during the call.

Q. The employee was referred for treatment. The employee and the supervisor do not think this injury needs to be treated. Should treatment be sought anyway?
A. Yes. It is always best to follow the advice of the RN and get treatment sooner rather than later. Minor injuries are often referred to seek treatment within 48-72 hours. If the employee refuses to seek treatment, that will be documented in the incident report.

Q. The employee does not want to call Company Nurse®. Should the supervisor call?
A. Yes. Call with the injury in formation; include if and where the employee was treated. The reports will be forwarded to the Risk Management and/or Human Resources department to alert them of the incident.

Q. What about injuries that occurred before the Company Nurse® service started, or injuries to employees who no longer work there?
A. Check with your company management or HR.

Q. The Employee has already been treated by their physician. Should the injury be reported?
A. Check with your company management or HR.

Q. Should an employee who is currently under medical care, call Company Nurse® for additional medical advice?
A. Once an employee is under a physician’s care, we cannot contradict the treating physician’s advice. The Nurse will remind the employee to follow the physician’s instructions.

Q. Will Company Nurse® provide general health care advice?
A. No. Company Nurse® should be called for work-related injuries only.
Frequently Asked Questions

Q. Will the employee be given some type of reference or call confirmation number?
A. Yes, we provide a call confirmation number that associates the employee’s injury to a specific report. This is not the same as the claim number assigned by your workers’ comp carrier.

Q. To whom does Company Nurse report injuries?
A. Company Nurse® reports all injuries to your HR/Risk Management and/or workers’ comp insurance carrier via an automated process as directed by the employer.

Q. What happens if the employee is on hold for an extended period of time waiting for a nurse?
A. The protocol is to answer every call - there is no voicemail. Calls are initially answered by an Injury Care Coordinator (ICC). During unexpected high volume time periods, the ICC will take a contact phone number, and a Nurse will return a call as soon as possible, typically within a few minutes.

Q. Is Company Nurse® my Workers’ Comp Insurance?
A. No. Company Nurse® provides the initial injury triage, offers care advice and initiates the injury reporting process. Your employer is responsible for Workers’ Compensation claims processing and administration.

Q. After I have been treated by a medical provider, do I need to call Company Nurse® back and update them with the treatment outcome and/or progress?
A. No. Company Nurse® does not need to know. Any updates of your condition after treatment should be provided to your employer or workers’ comp carrier.

For more information:
Please visit our website at www.companynurse.com
Or call us at 888 - 817 - 9282
Instructions for completing Form DWC-1
Employee Claim for Workers' Compensation Benefits

State law requires that the Employee's Claim for Workers' Compensation Benefits form (DWC-1 Form) be given to the employee within one working day of notice of injury. This does not include minor injuries such as first-aid unless the employee requests the form. State law does not require the employee to complete the form. It is the employee's right to choose not to do so. The employee uses it to request workers' compensation benefits. They should complete and sign the employee portion of the claim form. They need to describe the injury/illness and include every part of body affected. Returning the form is called filing the claim form (this notifies the employer that the employee is pursuing workers' compensation benefits).

STEP ONE: Issue injured employee DWC-1 form within one working day. They must complete the Employee Section and return it to their employer for claim to be processed.

Employee Section: PLEASE PRINT CLEARLY.
Line 1: Enter employee's full name. Enter today's date.
Line 2: Enter employee's home address
Line 3: Enter employee's city, state, and Zip Code.
Line 4: Enter date and time of injury.
Line 5: Enter address and description where injury occurred
Line 6: Enter description of the injury and the part of the body affected.
Line 7: Enter employee's social security number.
Line 8: Employee's signature.

STEP TWO: When employee returns the DWC-1 form, employer must finish the Employer Section and send form for processing.

Employer Section: PLEASE PRINT CLEARLY.
Line 9: Enter name of employer.
Line 10: Enter full address of the employer.
Line 11: Enter the date the employer first knew of the injury.
Line 12: Enter the date the claim was provided to the employee.
Line 13: Enter the date the employer received the completed claim form
Line 14: Enter the name of the insurance carrier or the adjusting agency, if applicable.
Line 15: Enter the policy number of the insurance.
Line 16: Employer's signature.
Line 17: Enter the title of the employer representative completing the claim form.
Line 18: Enter the telephone number of the representative completing the claim form.

STEP THREE: Fax a copy into the office below, as soon as possible, and mail the YELLOW COPY in for immediate processing. Please mail to:

Geri Simmons
Worker's Compensation Coordinator
Carmel Unified School District Office
Human Resources Department
Phone: 624-1546 x 2016
Fax: 626-4052
WORKERS' COMPENSATION CLAIM FORM (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and have recorded information at (800) 736-7401. An explanation of work- ers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation bene- fits or payments is guilty of a felony.

<table>
<thead>
<tr>
<th>Employee's Name</th>
<th>Social Security Number</th>
<th>Date of Injury</th>
<th>Time of Injury</th>
<th>Address and Description of Where Injury Happened</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY
INCIDENT INVESTIGATION FORM

Employer: ____________________________________________

Employee: ____________________________________________

Date of Report: ____________________________

Gender: O Male  O Female

DWC1 provided: O Yes  O No

Date Provided: ____________________________

Date of Hire: ____________________________

Status: O Regular Full-Time  O Part-Time  O Seasonal

Last Day Worked: ____________________________

Next Scheduled Day Off: ____________________________

Days of Injury: □ Monday  □ Tuesday  □ Wednesday
□ Thursday  □ Friday  □ Saturday  □ Sunday

Date of Injury: ____________________________

Time of Injury: ____________________________

Days of Injury: ____________________________

Status: ____________________________

Other: O Circulatory System  O Nervous System  O Respiratory System  O Other

PART OF THE BODY INJURED/AFFECTED - PLEASE CHECK ALL THAT APPLY:

- Scalp
- Right Eye
- Right Ear
- Mouth
- Neck
- Forehead
- Brain
- Left Eye
- Skull
- Nose
- Left Ear
- Teeth
- Right Shoulder
- Upper Back
- Upper Arm
- Shoulder
- Upper Back
- Upper Arm
- Chest
- Side/Ribs
- Chest
- Side/Ribs
- Elbow
- Elbow
- Abdomen
- Abdomen
- Lower Back
- Abdomen
- Lower Back
- Forearm
- Wrist
- Hand
- Wrist
- Hand
- Fingers
- Fingers
- Hip
- Hip
- Thigh
- Thigh
- Knee
- Knee
- Lower Leg
- Lower Leg
- Ankle
- Ankle
- Foot
- Foot
- Toes
- Toes
NATURE OF INJURY:

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<th>ABRASION</th>
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<th>FOREIGN BODY</th>
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<td>D</td>
<td>AMPUTATION</td>
<td>D</td>
<td>FRACTURE</td>
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<tr>
<td>D</td>
<td>BITE/STING</td>
<td>D</td>
<td>HEAT STRESS</td>
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<tr>
<td>D</td>
<td>BURN - CHEMICAL</td>
<td>D</td>
<td>HERNIA</td>
</tr>
<tr>
<td>D</td>
<td>BURN - CONTACT</td>
<td>D</td>
<td>INFECTION</td>
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<tr>
<td>□</td>
<td>BURN - ELECTRICAL</td>
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<td>LACERATION</td>
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<tr>
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<td>BURN-FLAME</td>
<td>D</td>
<td>MULTIPLE INJURY</td>
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<tr>
<td>D</td>
<td>BURN-FLASH</td>
<td>D</td>
<td>PAIN</td>
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<tr>
<td>D</td>
<td>CONTUSION</td>
<td>D</td>
<td>PUNCTURE</td>
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<tr>
<td>D</td>
<td>CRUSH</td>
<td>D</td>
<td>STRAIN/SPRAIN</td>
</tr>
<tr>
<td>D</td>
<td>DISLOCATION</td>
<td>D</td>
<td>OTHER: EXPLAIN</td>
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<tr>
<td>D</td>
<td>EXCESSIVE HEAT/CO LD</td>
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MEDICAL TREATMENT:

<table>
<thead>
<tr>
<th>D</th>
<th>SELF-TREATMENT</th>
<th>D</th>
<th>PRE-DESIGNATED PHYSICIAN</th>
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</thead>
<tbody>
<tr>
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<td>911</td>
<td>D</td>
<td>OCCUPATIONAL MEDICAL CLINIC</td>
</tr>
<tr>
<td>D</td>
<td>URGENT CARE</td>
<td>D</td>
<td>OTHER</td>
</tr>
<tr>
<td>□</td>
<td>EMERGENCY ROOM</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SAFETY RULES ESTABLISHED:

| □ | YES               |
| □ | No                |
| 0 | NOT ENFORCED      |

WITNESSES:

| 0 | YES |
| □ | No  |

NAMES (PLEASE USE WITNESS STATEMENT):

1
2
3
4
5

SUPERVISOR:

Do you have additional information on this accident?

| 0 | YES. IF SO, PLEASE USE THE SUPERVISOR'S INVESTIGATION FORM. |
| □ | NO |

Please complete the supervisor's safety review.
## SUPERVISOR'S SAFETY REVIEW

### JOB TASK - CHECK CATEGORY AND

- □ Ascending/Descending:
  - 0 Stairs
  - 0 Vehicle
  - 0 Ladder
  - 0 Equipment

- □ Banding:
  - 0 Installing
  - 0 Removing

- □ Clean Up - General

- □ Equipment:
  - 0 Adjusting
  - 0 Clearing
  - 0 Operating
  - 0 Repairing
  - 0 Other

- □ Forklift

- □ Material Handling:
  - 0 Pushing
  - 0 Pulling
  - 0 Lifting
  - 0 Powered

- □ Maintenance:
  - 0 Electrical
  - 0 Fueling
  - 0 Mechanical
  - 0 Cleaning
  - 0 Other

- □ Pallet Jack

- □ Truck:
  - 0 Loading
  - 0 Unloading

- □ Supervisory Task

- □ Tools:
  - 0 Hand
  - 0 Powered

- □ Walking Through Area

- □ Other - Explain below:

### UNSAFE ACT - CHECK CATEGORY AND TYPE:

- □ Bypassed:
  - 0 Guard/Barrier
  - 0 Safety Device

- □ Disregard:
  - 0 Instructions
  - 0 Rules

- □ Excessive Speed

- □ Failure:
  - 0 Lockout/Tagout
  - 0 Secure
  - 0 Warn
  - 0 Obtain/Assistance
  - 0 Use PPE

- □ Horseplay/Distraction

- □ Incorrect Method

- □ Impairment - Physical

- □ Improper:
  - 0 Lifting
  - 0 Loading
  - 0 Placement

- □ Inattention to Surroundings

- □ Operating:
  - 0 Without Authorization
  - 0 Equipment Un Safely

- □ Riding Hazardous Equipment

- □ Servicing Equipment in Operation

- □ Tried to:
  - 0 Avoid discomfort
  - 0 Save effort
  - 0 Save Time

- □ Unsafe
  - 0 Position
  - 0 Riding

- □ Using defective tools/equipment
### UNSAFE CONDITIONS - Check all applicable category and type:

<table>
<thead>
<tr>
<th>Category</th>
<th>Type</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Congestion</td>
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<td></td>
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<tr>
<td>Clothing - Hazardous</td>
<td></td>
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<tr>
<td>Control(s)</td>
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<td></td>
<td></td>
<td>Improper</td>
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<td>Defective</td>
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<td></td>
<td>Missing</td>
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<tr>
<td>Design limitation</td>
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<tr>
<td>Environment</td>
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<td></td>
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<td>Cold</td>
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<td>Poor Lighting</td>
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<td>Gasses/Fumes/Etc</td>
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<td>Noise</td>
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<td>Equipment:</td>
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<td>Exposed/Energized</td>
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<td>Operation</td>
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<tr>
<td>Fire/Explosion/Hazard</td>
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<tr>
<td>Handrails:</td>
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<td></td>
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<td>Inadequate</td>
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<td>Missing</td>
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<td>Not Installed</td>
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<tr>
<td>Housekeeping - Poor</td>
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<tr>
<td>Material - Defective</td>
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<tr>
<td>PPE:</td>
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<td></td>
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<td>Inadequate</td>
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<td>Improper</td>
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<tr>
<td>Sharp Object/Surface</td>
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<tr>
<td>Storage - Improper/Inadequate</td>
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<tr>
<td>Substance - Hazardous</td>
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<tr>
<td>Surface:</td>
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<tr>
<td></td>
<td></td>
<td>Slipping Hazard</td>
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<td></td>
<td>Tripping Hazard</td>
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<tr>
<td>Tool:</td>
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<td></td>
<td>Defective</td>
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<td>Not Available</td>
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<td></td>
<td></td>
<td>Other</td>
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<tr>
<td>Training:</td>
<td></td>
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<td></td>
<td></td>
<td>Inadequate</td>
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<td></td>
<td></td>
<td>Not given</td>
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<tr>
<td>Unexpected motion</td>
<td></td>
<td></td>
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<tr>
<td>Warning system - None/Inadequate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Windborne Dust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
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</tr>
</tbody>
</table>

### ADDITIONAL INFORMATION NOT COVERED ABOVE (EXPLAIN BELOW):

---

### ARE THERE OTHER INDIVIDUALS NOT YET CONTACTED WHO MAY HAVE INFORMATION ABOUT THIS INCIDENT?

---

### SIGNATURES:

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>SUPERVISOR:</td>
<td></td>
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</table>

### DATE SIGNED

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>EMPLOYEE:</td>
<td></td>
</tr>
</tbody>
</table>
Give a factual statement of your observation preceding, during and following the occurrence:

<table>
<thead>
<tr>
<th>Witness Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
Incident Report: Employee Injury or Illness
Carmel Unified School District (DISTRICT)

SECTION A: To be completed by employee

a. School_______________________ Department________________ Accidental Date________________ Hour________________

b. Employee's Name_________________ Soc. Sec. No. (Last 4)________________

c. Occupation_________________ Location of Accident (be specific)________________

d. To whom reported and title_________________ Date Reported________________ Hour________________

e. Description of Accident (include task being performed; step-by-step detail of incident, and tool, or object involved)________________

f. Specific body part injured________________ Name(s) of witness(s)________________

g. Employee's Signature_________________ Home Phone_________________ Date________________

SECTION B: To be completed by supervisor

1. What has been or will be done to prevent future similar injuries?________________

2. Does the employee have any input on how this type of injury can be avoided in the future?________________

3. Any inservice/training necessary for staff: Yes O No O If so, when will this be done?________________

4. Any physical deficiencies need correcting: Yes O No O If so, what steps have been taken?________________

5. Any procedural/operational changes necessary?________________

3. Check Medical Attention:
   - First Aid? LJ O Describe:________________
   - Visit Doctor? cO Name/Location________________
   - Hospital? (0) Name/Location________________

"If more than first aid given, be sure to fill out Form 5020 - Employer's Report of Occupational Injury or Illness."

7. Supervisor's Signature:_________________ Phone#:_________________ Date:________________