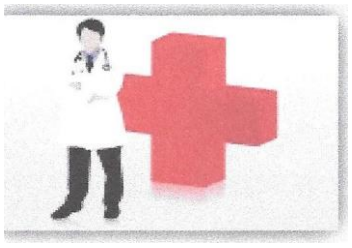
Carmel Unified School District

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!

P.O . Box 222700
4380 Carmel Valley Road
Carmel CA 93922

TEL: (831) 624-1546
FAX: (831) 626-4052

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@carmelunifi ed.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 _____

inTercare

tmesys®

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.

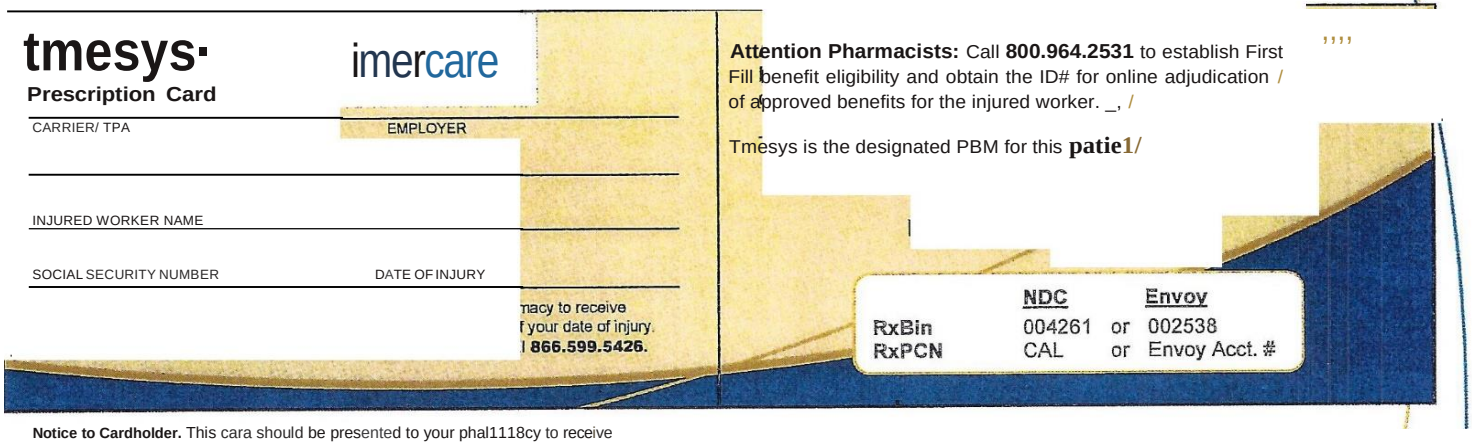
Injured Employee:

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

INecesitas ayuda en espafiol? Llame al 1. 866.599.5426



Notice to Cardholder. This cara should be presented to your phal1118cy to receive medicationfor your worl(-relaled injury. It is only valid wilhin 30 days of your date of injury. For info,mation regarding the program or to find nearby phannacies call **866.599.5426 .**

(To create a card for your wallet, cut along outer line and fold in half.)

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.**

IN CASE OF WORKPLACE INJURY:

ACCION d seguir en ca r/ .de un accidente en el trabajo

COMPANY
NURSE
Injury Hotline

1-855-602-5266

AVAILABLE 24 HOURS A DAY

m Injured worker notifies supervisor.
Empleado lesionado notifica a su supervisor.

r.:11 Supervisor / Injured worker immediately calls injury hotline.
Supervisor I Empleado lesionado llama inmediatamente a la lfnea de enf ermeros/as.

1:11 Company Nurse gathers information over the phone and helps IPli1j injured worker access appropriate medical treatment.
Profesional Medico obtiene informaci6n por telefono y asiste al empleado lesionado en localizar el tratamiento medico adecuado.

EMPLOYER NAME (NOMBRE DE COMPAN!A)

Carmel Unified School District

SEARCH CODE (C6DJGO DEL BUSQUEDA)

QI79

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.

Visit us online: www.CompanyNurse.com

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 Hot line 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 init ial 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 init ial reporting of employee incidents.

The advantage of a medical professional ass ist ing in directing the employee's medical treatment should result in cost savi ngs and fewer claims if first aid can be app li ed. 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 Hotline

E-Z REFERENCE GUIDE

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
  4. Injury details: Who? What? When? Where?
- Possible Outcomes as a result of the Call:
  - Self-care or basic first aid, OR
  - Referral to medical facility by a Nurse - Occ Health or Urgent Care or ER
- **IMPORTANT!**
  - *Translators are available for more than 170 different languages*
  - *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.

COMPANY NURSE
Injury Hotline

Frequently Asked Questions

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 wil l provide injury informat ion 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-t hreaten ing situations, **call 911 or transport directly to the ER immediately .** Call Company Nurse ® with any information that you have regar ding the incident once the sit uat ion has stabilized.

Q. Does Company Nur se® diagnose an injury over the telephone?

A. We do not diagnose injuries. We perform a triage process that guides the em ployee 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 alway s best to follow the advice of the RN and get treatment sooner rather than later . Min or inj ur ies are often referred to seek treatment with in 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 Com pany Nurse®. Should the supervisor call?

A. Yes. Call with the inj ury in form at ion; include if and where the employee was t reat ed. The reports will be forwarded to the Ris k Management and/or Human Resources department to alert t hem of the inciden t .

Q. What about injuries that occurred before the Company Nurse® service started, or injuries to employees who no longer work there?

A. Check wit h your company manag em ent or HR.

Q. The Employee has already been treated by their physician. Should the injury be reported?

A. Check wi th your company manage ment 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 ad vice. The Nurse will remind t he employee to follow the physician's inst ruct ions.

Q. Will Company Nurse® provide general health care advice?

A, No. Company Nurse® shoul d be called for work-related inj uries only .

COMPANY NURSE
Injury Hoffine

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 cla im number assigned by your workers ' comp carr ier.

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 init iall y answered by an Injury Care Coordinator (I CC) . During unexpected high volume time periods, the ICC will take a contact phone num ber, 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 adv ice and initiates the injury reporting process . Your employe r is responsible for Worke rs' Compensation claims processing and adm inistrat ion.

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 Nu rse® does not need to know. Any updates of your condition after treat m ent 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

iffiercare

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

iffiercare

INTERCARE HOLDINGS INSURANCE SERVICES INC

State of California
Department of Industrial Relations
DNISION OF WORKERS' COMPENSATION

P.O. Box 579 Roseville, CA 95661
1 (800) 771-5454 FAX 1 (877) 362-5050

Estado de California
Departamento de Relaciones lndustriales
DIVISION DE COMPENSACION AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACI6N DEL TRABAJADOR (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 em - ployer. You may call the Division of Workers' Compensation and hear 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 de- scribing worke rs' 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

Empleado: *Complete la seccion* ***"Empleado"*** *y entregue la forma a su empleador. Quedese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensacion al Trabajador al* ***(800) 736-7401*** *para oir informaci6n gravada. En la hoja cubierta de esta Jonna esta la explication de fos bene ficios de compensacion al trabajador.*

Ud. tambien deberfa haber recibido de su empleador unfolfeto describiendo los benficios de compensacion al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a prop6sito haga o cause quc sc produzca cualquier declaraci6n o representaci6n material falsa o fraudulenta con el fin de obtenc o negar beneficios o pagos de compensacion a trabajadorcs lesionados es culpable de un crimen mayor "felonia".

Employee-complete this section and see note above ***Empleado--complete esta seccion y note la notacion arriba.***

1. Name. *Nombre.*_____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Direccion Residencial.* -
3. City. *Ciudad.*_____ State. *Estado.*_____ Zip. *Codigo Postal.*_ _ _ _ _ _ _ _ _
4. Date of Injury. *Fecha de la lesion (accidente).*_____ Time of Injury. *Hora en que ocurrio.*_____ *a.m.*___ ___ .p.m.
5. Address and description of where injury happened. *Direccionllugar donde occurio el accidente.*_____

_____

6. Describe injury and part of body affected. *Describa la lesion y parte del cuerpo afectada.*_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

_____

7. Social Security Number. *Numero de Segura Social de! Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer-complete this section and see note below. ***Empleador-complete esta seccion y note la notacion abajo.***

9. Name of employer. *Nombre def empleador.* -
10. Address. *Direcci6n.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesion o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entrego al empfeado la peticion.*_____
13. Date employer received claim form. *Fecha en que el emp/e ado devolvio la peticion al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y direccion de la compaiifa de seguros o agenda adminstradora de seguros.*

INTERCARE HOLDINGS INSURANCE SERVICES INC P.O. Box 579 Roseville, CA 95661

15. Insurance Policy Number. *El numero de la poliza de Seguro.* _____
16. Signature of employer representative. *Firma def representante del empleador.* _____
17. Title. *Tftulo .*_____ 18. Telephone. *Telefono.* _

Employer: You are required to date this form and provide copies to your insure r or claims administrator and to the empl9yee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud.feche estaforma y que provea copias a su compaiifa de seguros, administrador de reclamos, o dependientelrepresentante de reclamos y al empleado que hayan presentado esta peticion dentro del plaza de* ***un dia htibil*** *desde el momenta de haber sido recibida laforma del empleado.*

EL FIRMAR ESTA FORMA NO SIGN/FICA ADMISION DE RESPONSABILIDAD

0 Employer *copy/Copia de/ Emp/eador* **0** Employee copy/ *Copia de/ Empleado* **0** Claims *Admini strator/Administrador de Rec/amos* O Temporary Reccipt/Recibo *de/ Empleado*

6/10 Rev.

OPTION #1

INCIDENT INVESTIGATION FORM

Employer: _____

Employee: _____

Date of Injury: _____

Time of Injury: _____

Days of Injury: ☐ Monday ☐ Tuesday O wednesday ☐ Thursday D Friday D Saturday O sunday

Last Day Worked: _____

Next Scheduled Day Off: _____

Date of Report: _____

Gender: 0 Male O Female

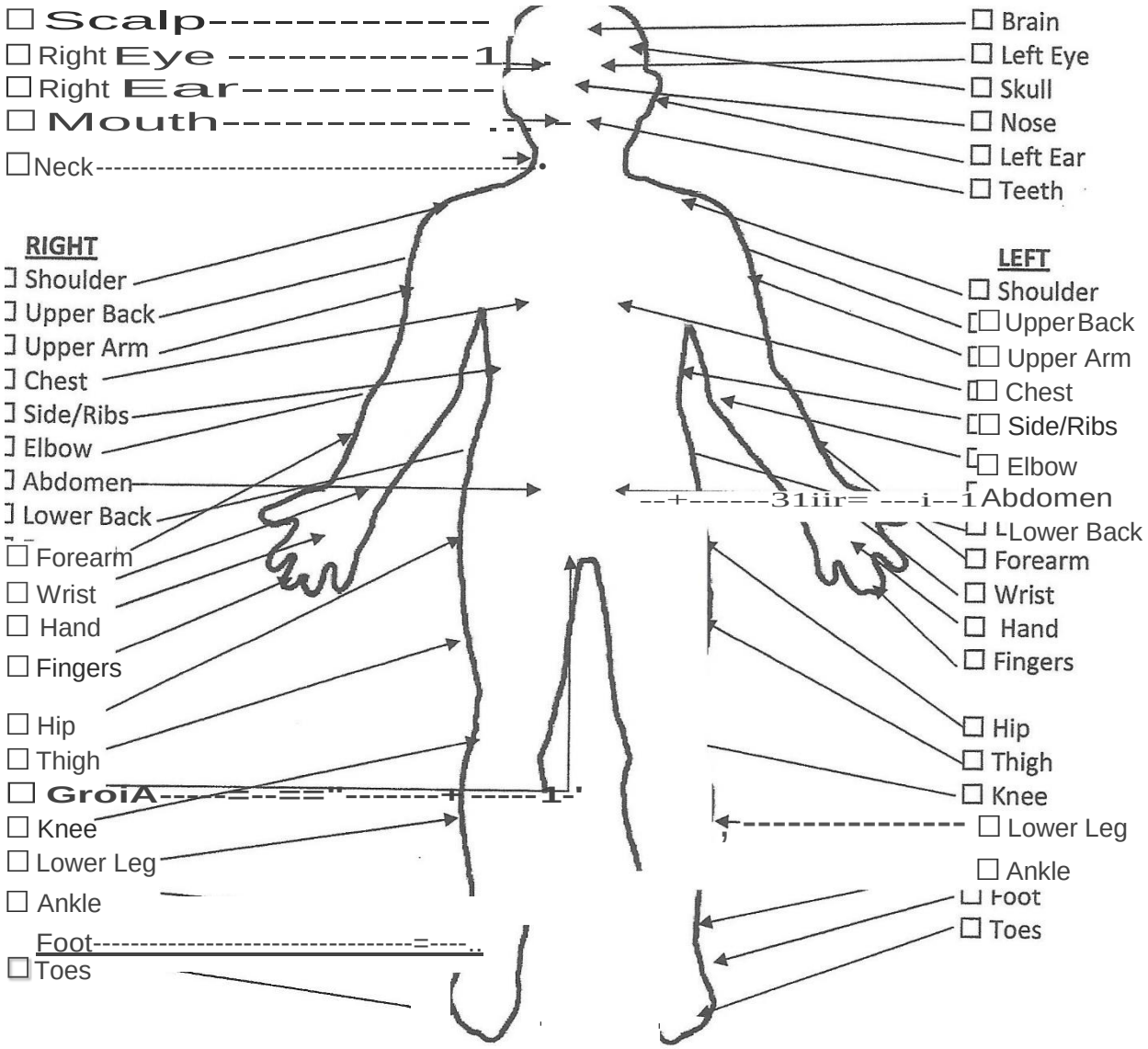
DWC1 provided: 0 Yes O No

Date Provided: _____

Date of Hire: _____

Status: D Regular Full-Time
0 Part-Time
D Seasonal

PART OF THE BODY IN!URED/AFFECTED - PLEASE CHECK ALL THAT APPLY:



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

NATURE OF INJURY:

D ABRASION	D FOREIGN BODY
D AMPUTATION	D FRACTURE
D BITE/STING	D HEAT STRESS
D BURN - CHEMICAL	D HERNIA
D BURN -CONTACT	D INFECTION
☐ BURN - ELECTRICAL	D LACERATION
D BURN-FLAME	D MULTIPLE INJURY
D BURN-FLASH	D PAIN
D CONTUSION	D PUNCTURE
D CRUSH	D STRAIN/SPRAIN
D DISLOCATION	D OTHER: EXPLAIN
D EXCESSIVE HEAT/COLD	

MEDICAL TREATMENT:

D SELF-TREATMENT	☐ PRE-DESIGNATED PHYSICIAN
☐ **911**	☐ OCCUPATIONAL MEDICAL CLINIC
D URGENT CARE	D OTHER
☐ EMERGENCY ROOM	

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	UNSAFE ACT CHECK CATEGORY AND TYPE:
☐ Ascending/Descending: o Stairs o Vehicle o Ladder o Equipment ☐ Banding: o Installing o Removing ☐ Clean Up - General ☐ Equipment: o Adjusting o Clearing o Operating o Repairing o Other ☐ Forklift ☐ Material Handling: o Pushing o Pulling o Lifting o Powered ☐ Maintenance: o Electrical o Fueling o Mechanical o Cleaning o Other ☐ Pallet Jack ☐ Truck: o Loading o Unloading ☐ Supervisory Task ☐ Tools o Hand o Powered ☐ Walking Through Area ☐ Other - Explain below:	☐ Bypassed: .o Guard/Barrier o Safety Device ☐ Disregard: o Instructions o Rules ☐ Excessive Speed ☐ Failure: o Lockout/Tagout o Secure o Warn o Obtain/Assistance o Use PPE ☐ Horseplay/Distraction ☐ Incorrect Method ☐ Impairment - Physical ☐ Improper: o Lifting o Loading o Placement ☐ Inattention to Surroundings ☐ Operating: o Without Authorization o Equipment Unsafely ☐ Riding Hazardous Equipment ☐ Servicing Equipment in Operation ☐ Tried to: o Avoid discomfort o Save effort o Save Time ☐ Unsafe o Position o Riding ☐ Using defective tools/equipment

UNSAFE CONDITIONS - Check all applicable category and type:

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

ADDITIONAL INFORMATION NOT COVERED ABOVE (EXPLAIN BELOW):

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

SIGNATURES:		DATE SIGNED
SUPERVISOR:		
EMPLOYEE:		

WITNESS STATEMENT

WITNESS NAME	JOB TITLE/POSITION	DATE OF STATEMENT
INJURED WORKER	DATE OF INCIDENT	TIME OF INCIDENT

Give a factual statement of your observation preceding, during and following the occurrence:

The above statement is a complete compilation of my understanding of the incident. I understand that this is a confidential statement, which i agree not to share without the expressed permission of this company or by court order.

Witness Signature | **Date**

OPTION #2

Monterey Educational
Risk Management Authority
· P.O. Box 3320
Salinas, CA 93912

Incident Report: Employee Injury or Illness

Carmel Unified School District
(DISTRICT)

SECTION A: To BE COMPLETED BY EMPLOYEE

a. School _____ Department _____ Accident 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)* _____

_____

_____ Regular work when injured: Yes / No

f. Specific bodypart 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 Aip .itjven:
First Aid? LJ). Describe: _____

Visit Doctor? cO Name/Location _____

Hospital? (0) Name/Location _____ _____ _____ _____ _____ _____ _____

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

T. Supervisor's Signature: _____ Phone#: _____ Date: _____

>ISTRIBUTION: Original - Merma Office Copy - District Office Copy • Personnel File

Reference: Ccr Title 8: S.3203 Revised: Mav 201?.