



WORKPLACE INJURY INSTRUCTIONS:

Paso 1: Evalúe la situación

Trabajador lesionado: Comuníquese inmediatamente con su Gerente en Turno e infórmele sobre su lesión.

Puede acudir a una de las clínicas o salas de emergencia sugeridas en el volante publicado. La mayoría de las clínicas cierran después de las 6:00 p. m., por lo que después de esa hora deberá acudir a la sala de emergencias.

Gerente en Turno: Si el trabajador está gravemente lesionado, llame al 911.

Paso 2: Tome acción

Trabajador lesionado: Acuda a la clínica más cercana si puede. Antes de irse, ayude a su gerente a completar el reporte FA1 en la parte inferior de este documento e imprima y lleve el formulario FA2 a su cita médica. Los formularios FA1 y FA2 están adjuntos al final de este documento.

Gerente en Turno: Debe IMPRIMIR y COMPLETAR el Reporte FA1 y entregar el formulario FA2 al trabajador para que lo lleve consigo. (Los documentos están en la siguiente página).

Paso 3: Documentos

Trabajador lesionado: Lleve el formulario FA2 con usted a la clínica u hospital. Asegúrese de compartir ese formulario con el centro médico.

FA1: Complete y envíe por correo electrónico a CLAIMSREPORTING@ERNWEST.COM

FA2: El formulario en blanco debe acompañar al trabajador lesionado a la clínica o al médico.

Trabajador lesionado: No necesita un abogado para recibir estos servicios.

¿Tiene preguntas? Llame a Shelly Boopor al 800-851-4191

EMPLOYEE INCIDENT REPORT {FA1}

Company Name: _____ Location Name: _____

PART I TO BE COMPLETED BY SUPERVISOR AND PAYROLL

Employee:	Job Title:	Time Shift Began: _____ AM / PM (circle)
Date of Incident:	Time of Incident: _____ AM / PM (circle)	Reported to Employer: ____/____/____
Employee's Home or Mailing Address:	Home Phone: () _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Date of Hire: ____/____/____	Last Full Day Worked: ____/____/____
	Date of Birth: ____/____/____	

Seen by: _____

[] Emergency Room [] Urgent Care [] Other

Treating Caregiver's Name, Address & Phone: _____

1) Were prescription drugs prescribed? Yes No

2) Will employee lose time from work? Yes No

3) Was employee placed on modified duty? Yes No

4) Was worker hospitalized overnight? Yes No

5) Was the incident fatal? Yes No

6) If fatal, date of death _____/_____/_____

Describe what employee was doing just before the incident occurred including the activity, tools, equipment, and/or material being used: _____

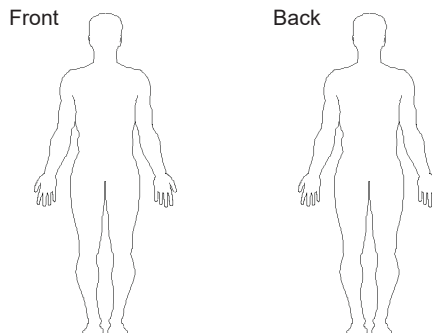
Describe how the incident occurred, including the activity being performed and objects, people associated with the injury: _____

If applicable what object or substance directly harmed the employee: _____

Part of Body (Circle side if applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Hand (L or R) | <input type="checkbox"/> Knee (L or R) |
| <input type="checkbox"/> Eyes (L or R) | <input type="checkbox"/> Finger | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Leg (L or R) | <input type="checkbox"/> Entire |
| <input type="checkbox"/> Mouth | <input type="checkbox"/> Foot (L or R) | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Toes | <input type="checkbox"/> Teeth |
| <input type="checkbox"/> Shoulder (L or R) | <input type="checkbox"/> Internal | <input type="checkbox"/> Groin |
| <input type="checkbox"/> Back | <input type="checkbox"/> Multiple | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Ankle (L or R) | <input type="checkbox"/> Elbow (L or R) |
| <input type="checkbox"/> Arm (L or R) | <input type="checkbox"/> Wrist (L or R) | <input type="checkbox"/> Rib |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Face | |

MARK INJURED AREA(S) BELOW



1) Rate of Pay _____ per mo/wk/hr 2) Days Worked per Week _____ 3) Hours per Week _____

4) Health Benefits (circle) Y or N 5) Monthly benefits (med/vision) paid \$ _____ per mo/wk/hr

PAYROLL Fill out this section if employee misses more than one day of work.

PART II TO BE COMPLETED BY EMPLOYEE

Was injury work related? Yes No

I understand light work is available to me. Yes No

Employee statement of how incident occurred: _____

MEDICAL RELEASE AUTHORIZATION: I hereby authorize my physician, clinic, hospital, agency, or therapy provider to release to my employer's representative any relevant medical records regarding current or previous treatment(s) that has been furnished to me.

Employee's Signature _____ Date _____

Form Completed By: _____ Phone: _____ Date: _____ Title: _____

OSHA Log case number _____ (transfer the case number from the OSHA 300 log after recording the case)

Return To Work Form {FA2}

We are committed to returning our team member back to work as soon as medically possible and we need your help! Please give this document back to our employee during your visit with them, they are required to return this to us within one (1) business day so we can try and assist in their rehabilitation by providing modified work. **YOU CAN BILL FOR FILLING OUT THIS FORM BY USING L&I CODE 1074M.**

Employee: _____ Company: _____ L&I Claim No.: _____

Date of injury: _____ Today's date: _____ Return visit on _____ First injury/condition of this type? Yes No

Initial Diagnoses: _____ Estimated full-duty release date _____

Treatment Plan (check all that apply)

- Physical Therapy _____ times per week, for _____ weeks Occupational Therapy _____ times per week, for _____ weeks
- Surgery - anticipated date _____ CT Scan EMG Other _____

Referral to other providers: None Neurology Orthopedic Surgeon Psychiatrist/Occ. Med. Rheumatologist Other _____

We have identified four (4) stages of modified duty, unless otherwise specified here _____ (indicate # of hours per day & days per week) we are assuming this modified duty is approved for 40 hours per week. Below please check the appropriate stage to which our employee is released and feel free to cross out any task our employee should not be performing.

Stage 1: Work at this stage would include such tasks as inspecting glasses, dishes, cutlery for cleanliness/customer safety; cleaning and filling shakers/grinders, sugar caddies; tending drink/salad/desert station(s); seating customers; greeting customers; tending bread station; operating the cash register; wrapping silverware; preparing small food items (e.g. cutting vegetables, weighing portions, preparing cook station items; setting tables, wiping down and cleaning of items (e.g. tables, menus, seats, counters, coolers).

Standing: Occasional **Carrying:** 1 - 5 lbs. **Grasping/Handling:** Frequently
Sitting: Occasional **Lifting:** 1 - 5 lbs. **Bending/Squatting:** Occasional
Walking: Rare/Occasional **Push/Pull:** 1 - 5 lbs. **Twisting/Climbing:** Rare

Stage 2: Performing all tasks listed under "Stage 1" above as well as delivering drink orders; delivering small orders to tables; stocking dishes; washing dishes; stocking food stations; busing small tables; cleaning and arranging food coolers; mopping floors; preparing larger food items.

Standing: Occasionally **Carrying:** 6 - 15 lbs. **Grasping/Handling:** Continuously
Sitting: Occasional **Lifting:** 6 - 15 lbs. **Bending/Squatting:** Occasionally/Frequent
Walking: Occasional **Push/Pull:** 6 - 15 lbs. **Twisting/Climbing:** Occasional

Stage 3: Performing all tasks listed under "Stages 1 and 2" above and taking out garbage; receiving food orders; arranging tables or chairs; taking orders to tables.

Standing: Frequently **Carrying:** 16 - 30 lbs. **Grasping/Handling:** Continuously
Sitting: Rare **Lifting:** 16 - 30 lbs. **Bending/Squatting:** Frequent
Walking: Frequently **Push/Pull:** 16 - 30 lbs. **Twisting/Climbing:** Frequent

Stage 4: Return to full duty no restrictions:

DEFINITIONS

- Rare:** 0% - 10%
- Occasional:** 11% - 33%
- Frequent:** 34% - 66%
- Constant:** 67% - 100%

WAC 296-19A-030 requires doctors to respond to requested information in a timely manner, which includes physical capabilities or restrictions.

MEDICAL PROVIDER: This form should be returned to the injured employee during their appointment to facilitate a quick return to work. If this is not possible please fax it to 877-717-0590 and it will be forwarded to the employer.

Doctor Signature _____

REQUIRED

Date _____

Medical provider name and phone _____

____/____/____

RE: L&I Claim # _____

Dear _____

I am pleased to offer you employment with _____ which will accommodate your current physical capacities. The job is that of _____. This job is available on a reasonably continuous basis and additional modifications can be made based on objective medical findings and associated restrictions. The details of this offer are subject to all hiring and employment requirements and may include verification of employment eligibility and drug testing. A detailed description of the job which has been approved by a medical provider has been attached to this letter. The specifics of your employment include but are not limited to:

- 1) You will report for duty on ____/____/____ at the following address:

- 2) Your shift will begin at ____:____ and will end at ____:____. You will be scheduled for ____ (shift/hours) per week. This is based on your pattern of employment established prior to the date of your injury.
- 3) You will report to _____, who will act as your direct supervisor, and he/she has been advised of your physical capacities.
- 4) Your wage will be \$_____ per hour and you will receive benefits in accordance with our company policy.
- 5) If you have additional medical appointments, you must schedule them outside of work hours unless approved by a supervisor, or scheduled by L&I.
- 6) As necessary, training will be provided to help satisfactorily complete assigned duties not previously performed.
- 7) Should you experience any difficulties in the performance of your duties; you are to report them to _____ (**supervisor's name**) as soon as possible.
- 8) This employment relationship is at-will which means both we as the employer and you as the employee are free to end this relationship at any time with or without cause.

Should you have any questions regarding this letter, please contact me at (____) _____ - _____. Please contact me by telephone no later than ____/____/____. to accept or decline this job offer.

Please check the appropriate box below and return this letter to me, by hand, or post-marked no later than ____/____/____. If you do not contact me by ____/____/____, and/or you do not show up for work on ____/____/____, your time loss benefits will most likely end.

I ACCEPT THIS OFFER

I DECLINE THIS OFFER (may affect L&I time loss benefits)

Employee's Signature Date

Sincerely,

Encl.: Approved Job Analysis
Cc: Claims Manager, ERNWest, Vocational Counselor, Attending Doctor