Employee: Please present this to your doctor when reporting for treatment.

Notice to Doctor:

_____ has reported an on-the-job

injury that occurred on _____ _____, 2_____.

Please send your report directly to our insurer:
CITIES AND VILLAGES MUTUAL INSURANCE COMPANY
9898 W. BLUEMOUND RD.
WAUWATOSA, WI 53226-4319

HR/Supervisor Signature: _____

Date: _____

NOTE:
This is not an acceptance of liability.
The state worker's compensation administrative agency or the insurance company will advise you further.

City of Onalaska
Worker's Compensation Reporting Procedures

1) Employee to fill out and sign Employee Injury Report as soon as possible following the injury
2) Supervisor to review and sign form
3) Supervisor to give employee Notice to Doctor form if employee intends to seek medical treatment
4) Supervisor to advise employee to bring back a work status slip from the doctor immediately following the appointment
5) Supervisor to send Report of Injury form to Human Resources within **24 hours** of the injury so the state form can be filled out.
6) Human Resources should be notified whether employee is seeking medical attention
7) Supervisor to review work status slip and assign employee to light duty task if employee is restricted and light duty work is available coordinating this with approval from Human Resources
8) Supervisor to send a copy of all return to work forms to Human Resources
9) Supervisor to notify Human Resources of work status (no lost time, working light duty, off work until…)
10) Supervisor should notify Human Resources of any change in status (i.e. now seeking medical treatment, employee scheduled for surgery, returned to work, returned from light duty to full duty)
11) Human Resources to send WKC-12 first report of injury form to CVMIC within 7 days of the injury and to notify CVMIC whether employee is working full duty, light duty or off work. Human Resources also should notify CVMIC on any changes in the employee's status as outlined in #10.

CITY OF ONALASKA
Employee Injury Report

This report is to be completed for any accident where an injury or illness occurred in the course of employment. **Return to Human Resources no later than 24 hours following the accident/injury, or if on the weekend, the following Monday.**

INJURED EMPLOYEE: Date _____

Employee's Name: _____ Department _____

Address: _____ Phone (____)_____

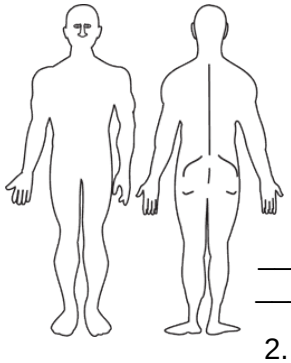
Number & Street City State Zip Code

Sex: Male ☐ Female ☐ Job Title _____

NATURE OF ACCIDENT: Date of Injury ___/___/____ Time of Injury _____ ☐AM ☐PM

Time Shift Began: _____ ☐AM ☐PM

Any prior injuries/disabilities? _____



To assist us in knowing what body part(s) were affected please circle the body part(s) affected on the diagram to the left.

1. WHAT WAS THE INJURY OR ILLNESS? (Describe the part of the body that was affected and how it was affected; be more specific than "hurt," or "sore." *Examples*: "strained lower back;" "chemical burn, right hand;" "carpal tunnel syndrome, left wrist.")
   (INDICATE LEFT OR RIGHT)

_____

_____

2. WHAT HAPPENED? (Describe how the injury occurred. Examples: "When ladder slipped on wet floor, fell 20 feet;" "Was sprayed with chlorine when gasket broke during replacement.")

_____

_____

3. WHAT WERE YOU DOING JUST BEFORE THE ACCIDENT OCCURRED? (Describe the activity, as well as the tools, equipment, or material you were using. Be specific. Examples: "Climbing a ladder while carrying roofing materials;" "spraying chlorine from hand sprayer."

_____

_____

4. WITNESSES: _____
5. WERE PHOTOS TAKEN OF THE ACCIDENT/INJURY? ☐ Yes ☐ No If yes, submit with the accident Report or directly after being developed.

MEDICAL TREATMENT:

Was first aid or medical treatment needed? ☐ Yes ☐ No ☐ May be needed

If yes, answer the following:

a) Was medical treatment/first aid given *at worksite*? ☐ Yes ☐ No
   - Type of treatment received or first aid administered?

     _____
   - By whom?

     _____

b) If treatment was given *away from the worksite*, where was it given?
   ☐ Gundersen Lutheran ☐ Franciscan Skemp ☐ Other (specify) _____

c) Was treatment given in an emergency room? ☐ Yes ☐ No

d) Date employee returned to work? _____ **- OR -** Estimated date of return? _____

Is this a new injury? ☐ Yes ☐ No

If you have had previous problems with this condition/injury in the past, please state when and how the injury occurred and type of medical treatment received at that time, if any. List name of physician and medical facility.

_____

_____

Please keep the City informed of the status of your injury. Submit any progress reports from doctor's visits to your supervisor or Human Resources directly after your appointment. Thank you.

SUPERVISOR REPORT:

Describe what happened. _____

_____

_____

Describe any unsafe conditions that existed. _____

_____

If applicable, was employee using any type of safety equipment? _____

_____

What changes (mechanical/procedural) have been made to prevent this in the future, if any? _____

_____

_____

State how the injury could have been prevented and what preventative measures can be taken in the future to avoid injuries of this nature. None

_____

_____

Was the employee involved in a vehicle accident? ☐ Yes ☐ No If yes, contact Human Resources to determine if a drug screen at Gundersen Lutheran Clinic is necessary. *(Per Policy 6.05, an employee must submit to an alcohol and controlled substance test in the following situations: the accident involved personal injury or the loss of human life; or the accident involves significant damage to property; or the employee receives a citation under state or local law for a moving traffic violation arising from an accident.)*

Report prepared by: _____ Date _____

Reviewed by Immediate Supervisor: _____ Date _____

Reviewed by Department Head*: _____ Date _____

**This may be the same as your immediate supervisor. If so, it does not require a second signature.*

Reviewed by Human Resources Dept _____ Date _____

For office Use Only:

Date of Birth ___/___/____ Social Security No._____-_____-_____ Date of Hire ___/___/____