



# COUNTY OF KENOSHA

## EMPLOYEE ACCIDENT-INJURY-ILLNESS FORM

Below are the INSTRUCTIONS for completing the following forms:

ACCIDENT / INJURY REPORT

- 1) Report Accident/Injury to your supervisor/manager as soon as possible.
- 2) Complete SECTION 1 of this form and submit it to your supervisor/manager.
- 3) Type or print legibly and provide all requested information.
- 4) Your supervisor or office manager must fax completed Section 1 to toll free fax number 1-877-285-6918. No cover page is required.

WORKER'S COMPENSATION CLAIM

- 1) Immediately notify your supervisor/manager if you are injured at work and need medical attention.
- 2) Complete SECTIONS 1 & 4 for work related injuries and illnesses that require medical attention and submit to your supervisor as soon as possible.
  - a) SECTION 4: Put your name, address and date of birth under "Patient" title. Put your doctor's name, address and phone number under "Records Released From" title. Under "Information To Be Released" check the "Other" box and circle "All records current and future related to diagnosis identified in Section 2 Item 3". Check any other appropriate boxes. Check the appropriate box under "Purpose or Need for Disclosure" title. Read remainder of form, sign and date at the bottom.
- 3) Advise your physician that the County makes every effort to accommodate medical restrictions.
- 4) Provide your physician with completed SECTIONS 1 & 4 and SECTIONS 2 & 3. Have your physician complete SECTIONS 2 & 3 and submit ALL SECTIONS to your supervisor as soon as possible.
- 5) Your supervisor or office manager must fax ALL SECTIONS to toll free fax number 1-877-285-6918. No cover page is required.
- 6) You are REQUIRED to NOTIFY your supervisor/manager of any work restrictions/limitations, anticipated time off work including projected return to work date, and updates to these as they change. SECTION 3: Work Status Report on page 4 may be used for this purpose.

ACCIDENT AND SICKNESS PAY MAINTENANCE CLAIM

- 1) Notify your supervisor as soon as possible, and submit completed SECTIONS 1, 2, 3 & 4 at least 7 days in advance of any unplanned or known A&S related absences.
  - a) Elective surgeries should be scheduled with your department's needs in mind and away from holidays.
- 2) Complete SECTIONS 1 & 4 for non work-related injuries and illnesses that medically disable you from work.
  - a) SECTION 4: Put your name, address and date of birth under "Patient" title. Put your doctor's name, address and phone number under "Records Released From" title. Under "Information To Be Released" check the "Other" box and circle "All records current and future related to diagnosis identified in Section 2 Item 3". Check any other appropriate boxes. Check the appropriate box under "Purpose or Need for Disclosure" title. Read remainder of form, sign and date at the bottom.
- 3) Provide your physician with completed SECTIONS 1 & 4 and SECTIONS 2 & 3. Have your physician complete SECTIONS 2 & 3.
- 4) Submit ALL SECTIONS to the Personnel Office if you wish your medical information be kept confidential. To expedite the submission use Personnel's confidential FAX (262) 653-2463.
- 5) You must also submit a copy of SECTION 3 to your supervisor/manager.
- 6) You are REQUIRED to NOTIFY your supervisor/manager of any work restrictions/limitations, anticipated time off work including projected return to work date, and updates to these as they change. SECTION 3: Work Status Report on page 4 may be used for this purpose.
  - a) Physical work restrictions/limitations and dates of leave are not considered protected health information.
- 7) It is your responsibility to ensure Personnel receives this completed from in a timely fashion.
  - a) Benefits may be suspended or denied with insufficient documentation or late reporting.
- 8) Notify your supervisor or manager of your work status after every appointment with a physician. You must also submit to the Personnel Office a written status report including applicable medical restrictions after every appointment with a physician. SECTION 3: Work Status Report on page 4 may be used for this purpose.
- 9) You may be required to return to limited duty as soon as your medical restrictions permit. However, the County can not guarantee the availability of limited duty work, and may opt not to accommodate medical restrictions.
- 10) You must cooperate with requests from the Personnel Office to participate in independent medical evaluations or nurse case management.



# COUNTY OF KENOSHA

## EMPLOYEE ACCIDENT-INJURY-ILLNESS FORM

### SECTION 1

#### GENERAL STATEMENT & INFORMATION

*Check one box*

- ACCIDENT / INJURY REPORT (Not seeking medical care at this time FAX to 1-877-285-6918)
- WORKER'S COMPENSATION CLAIM (Seeking medical care due to work injury FAX to 1-877-285-6918)
- ACCIDENT AND SICKNESS PAY MAINTENANCE CLAIM (Disabled from work due to non work-related accidental injury or illness FAX to 262-653-2463)

Full Legal Name \_\_\_\_\_

Job Title \_\_\_\_\_ Department/Division \_\_\_\_\_

Date of Injury or Onset of Illness \_\_\_\_\_

First Day Disabled/Unable to Work \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City & State \_\_\_\_\_

What is the injury or illness? (Please be specific in your description of the injury or illness and identify the body part affected) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If you suffered a work-related injury complete this boxed section. If claiming A&S do not complete this boxed section.

What was your wage at time of injury? \_\_\_\_\_  Full Time  Part Time

What is your normal start time? \_\_\_\_\_ What time did you actually begin work? \_\_\_\_\_

What time did the accident / injury occur? \_\_\_\_\_

What were you doing just before the accident / injury occurred? \_\_\_\_\_

What happened / how did the injury or work-related illness occur? \_\_\_\_\_

What object or substance directly harmed you? (Leave blank if this does not apply to the incident) \_\_\_\_\_

Witnesses to the Accident / Injury \_\_\_\_\_

If you seek medical care for the above stated injury or illness please provide the name, phone number and address of the physician that will be treating you.

Physician name \_\_\_\_\_ Office Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City & State \_\_\_\_\_

Who is your Supervisor? \_\_\_\_\_ Supervisor's Office Phone \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_



# COUNTY OF KENOSHA

## EMPLOYEE ACCIDENT-INJURY-ILLNESS FORM

### SECTION 2

#### PHYSICIAN'S STATEMENT

This form is required to determine wage benefit eligibility for Kenosha County employees. Please note that **KENOSHA COUNTY ACCOMMODATES MEDICAL RESTRICTIONS WHENEVER POSSIBLE INCLUDING TEMPORARY REASSIGNMENTS TO SEDENTARY WORK.** This form is your certification that our employee is temporarily totally disabled or is able to return to work with clearly defined physical limitations. We appreciate your time in completing this form in its entirety.

1) Please provide Patient's name \_\_\_\_\_

2) First date of disability \_\_\_\_\_ Date of first examination \_\_\_\_\_

3) Diagnosis and description of injury / illness (If pregnancy, please give the approximate date of delivery)

\_\_\_\_\_

\_\_\_\_\_

4)  Yes  No Did this disability occur as the result of the patient's employment (work-related)? (If yes, please explain)

\_\_\_\_\_

5)  Yes  No Did the disability occur as the result of a traumatic accident/injury? (If yes, please explain)

\_\_\_\_\_

6)  Yes  No Does this injury/illness require surgery (as defined by the agency for healthcare research & quality)?

Date surgery performed \_\_\_\_\_

Please describe the surgical procedure \_\_\_\_\_

\_\_\_\_\_

7)  Yes  No Will the patient be admitted for an IN-Patient hospital stay as the result of this injury/illness?

Admitted to which hospital? \_\_\_\_\_ Date of hospitalization \_\_\_\_\_

8)  Yes  No Kenosha County offers numerous light duty options within and/or outside the employee's regular job duties.

Is this patient able to perform any restricted or limited duty work? If so, please complete the Section 3: Work Status Report on page 4.

\_\_\_\_\_

9)  Yes  No Is this patient temporarily totally disabled and unable to work as the result of his/her injury/illness?

If yes, please provide a projected return to work date \_\_\_\_\_

Attending physician (please print) \_\_\_\_\_

Attending physician's address \_\_\_\_\_ City & State \_\_\_\_\_

Physician's office phone number \_\_\_\_\_

Attending physician's signature \_\_\_\_\_ Date \_\_\_\_\_



# COUNTY OF KENOSHA

## EMPLOYEE ACCIDENT-INJURY-ILLNESS FORM

### SECTION 3 WORK STATUS REPORT

**EMPLOYEE:** Have your physician complete this form after each visit. Submit the completed form to your supervisor.  
**PHYSICIAN:** Kenosha County offers numerous light duty options within and/or outside the employee's regular job duties. The County is requesting the below information so as to safely assign work within the specified physical limitations. Please complete this form exclusive of any HIPAA protected information as it will be returned to the employee's supervisor and shared between management staff for appropriate work assignment.

Name:		Date of Injury or Illness:		Date of Surgery:	
<b>Work Status:</b>	No Work	Modified Duties	Graduated RTW	Full Duties	Overtime: Yes / No
May return to work on:					
Next appt.:		Days/weeks	Next Appt. Date:		

<b>The Patient is capable of performing the following degree of work:</b>						
Sedentary Work:	Lift 10# maximum; Occasionally carry small objects					
Light Work:	Lift 20# maximum; Frequently lift/carry up to 10#					
Medium Work:	Lift 50# maximum; Frequently lift/carry up to 25#					
Heavy Work:	Lift 100# maximum; Frequently lift/carry up to 50#					
Very Heavy Work:	Lift in excess of 100#; Frequently lift/carry up to 50#					
<b>Patient is Able to:</b>	Never	Occasionally	Frequently	Continuously	<b>Note: In terms of a work day</b>	
Bend					"OCCASIONALLY" equals 1%-33%	
Squat						
Crawl						
Climb					"FREQUENTLY" equals 34-66%	
Crouch						
Kneel					"CONTINUOUSLY" equals 67%-100%	
Push/Pull						
Twist						
Walk	1 2 3 4 5 6 7 8+ (Number of Hours)					
Sit	1 2 3 4 5 6 7 8+ (Number of Hours)					Needs Frequent Change of Position
Stand	1 2 3 4 5 6 7 8+ (Number of Hours)					
Drive	Number of hours:					

NO work AT or ABOVE shoulder level:	Both Arms / Left Only / Right Only	Sling / Immobilizer / Splint / Cast: Left / Right
NO Use of Left / Right hand	May use Left/ Right as light assist only	Light paper work only Left / Right hand
NO Repetitive work Left / Right hand	May lift 5# 10# 20# with : Left/Right hand	Elevate Left/ Right upper extremity
NO Weight Bearing	Weight bearing as tolerated: Left / Right lower extremity	USE OF: wheel chair / walker / crutches / cane
NO use of feet for repetitive movements such as operating foot controls: Left / Right / Both feet		Elevate Left / Right lower extremity

RETURN TO WORK with NO restrictions on: \_\_\_\_\_ OR with above restrictions on: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# COUNTY OF KENOSHA

## EMPLOYEE ACCIDENT-INJURY-ILLNESS FORM

### SECTION 4

#### STATEMENT OF UNDERSTANDING AND AUTHORIZATION TO ACCESS MEDICAL RECORDS

Your medical record will not be accessed unless medical substantiation or clarification is deemed necessary to determine benefit eligibility.

#### Patient (Employee / Benefit Claimant):

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City & State \_\_\_\_\_

#### Records Released From (Employee's treating physician):

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City & State \_\_\_\_\_

#### Records Released To:

Kenosha County HIPAA Compliance Officer, 2<sup>nd</sup> Floor, 1010 56<sup>th</sup> Street, Kenosha, WI 53140. Confidential Fax (262) 653-2463.

#### Information To Be Released: (Check all applicable categories)

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Complete copy of all records  | <input type="checkbox"/> Progress Notes                     | <input type="checkbox"/> EKG/EMG/EEG |
| <input type="checkbox"/> Labs  | <input type="checkbox"/> Immunizations                      | <input type="checkbox"/> ER/UR       |
| <input type="checkbox"/> X-Rays  | <input type="checkbox"/> Counseling and Consultation visits | <input type="checkbox"/> PT/SP/OT    |
| <input type="checkbox"/> Other _____ All records current and future related to diagnosis identified in Section 2 item 3. |   |                                      |

In compliance with Wisconsin Statutes which require special permission to release otherwise privileged information, please release records pertaining to: (Check all applicable conditions)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Mental Health                | <input type="checkbox"/> Alcohol Treatment/Evaluation | <input type="checkbox"/> Developmental Disabilities            |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Drug Treatment/Evaluation    | <input type="checkbox"/> HIV Tests, AIDS/AIDS Related Incident |
| <input type="checkbox"/> Other _____                  |   |  |

#### Purpose or Need for Disclosure:

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Receipt of Kenosha County Accident & Sickness pay maintenance benefits | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Receipt of Worker's Compensation benefits                              |                                      |

In signing this consent form, I acknowledge that:

- I understand that authorizing the disclosure of my health care information is voluntary, and that I can refuse to sign this authorization.
- I understand benefits may be suspended or denied without adequate medical substantiation.
- I am authorizing release of all records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the re-disclosure of such materials is hereby authorized. Also, I am authorizing the release of any other information from whatever source regarding my physical or mental health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or any other health care provider.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization.
- I may revoke this authorization at any time by a written request to Kenosha County, unless my medical records have already been released.
- I may obtain a copy of the disclosed records and information, upon written request to Kenosha County.

- My personal health information disclosed pursuant to this authorization may be re-disclosed and may no longer be protected by federal law.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from the date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy shall be as valid as the original.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

I also agree to submit to independent medical examinations, return to work evaluations, functional capacity evaluations, nurse case management and/or fitness for duty examinations by a physician or nurse case manager or other appropriate health care professional of the County’s choice as deemed necessary by the Division of Personnel Services.

My signature below also verifies my acknowledgement of the following Kenosha County Uniform Work Rules and Family & Medical Leave Act Policies:

- Employees claiming worker’s compensation must immediately notify their supervisor or management of the occurrence of the injury to ensure that the claim is filed in accordance with the Wisconsin Worker’s Compensation Act.
- Employees who are off work for more than four (4) consecutive workdays for a medical reason must submit a return-to-work slip or proof of continuing disability from their physician.
- Employees requesting benefits under the accident and sickness pay maintenance benefit plan or family and medical leave must complete the required form and submit it to the Personnel Office for approval. Except in extenuating circumstances, the form must be submitted before the time off is taken. Failure to complete notification procedures as directed may result in the delay or loss of the benefit, or in the employee forfeiting any rights to pay for the time period which elapsed prior to notification.
- Employees who will be absent from work due to family medical leave, worker’s compensation, or under the accident and sickness pay maintenance benefit plan must immediately notify their supervisor or management in addition to the Personnel Office, of the absence and the duration of the absence.
- Employees who are absent from work and receiving benefits under worker’s compensation or the County’s accident and sickness pay maintenance plan shall notify their supervisor or management of their work status after every appointment with a physician, not to include routine therapy appointments. Employees shall also submit to the Personnel Office a written status report including applicable medical restrictions after every appointment with a physician, not to include routine therapy appointments. For those cases where physician appointments are infrequent, proof of continuing disability from a physician is required at least every thirty (30) days in order to continue to receive benefits.
- Employees shall not work for another employer while on paid or unpaid leave unless authorized by the County.
- Employees shall not engage in conduct or activities which serve to lengthen the healing period of an injury or illness or that prevents them from returning to work. Employees shall not exceed their medical restrictions at or outside of work.
- Employees shall not give any incomplete, misleading or false information of any kind. This includes, but is not limited to, records, time cards, absences, time off, incident, accident, injury or illness records. Also, employees shall not falsely state or make a claim of illness or injury. Employees found to have created a false report or record which would cause the County to pay out funds inappropriately may, as part of the disciplinary action, be required to reimburse the County.
- ACCIDENT & SICKNESS BENEFIT AND FAMILY & MEDICAL LEAVE: The County will require that an employee receiving pay under the Accident & Sickness (A & S) benefit whose accident or illness qualifies as Family & Medical Leave, be charged Family & Medical Leave while receiving A & S benefit pay. The designation will be noted on the employee pay stub (pay check) or remittance advice (direct deposit).
- WORKER’S COMPENSATION AND FEDERAL FAMILY & MEDICAL LEAVE: The County will require that an employee on worker’s compensation, whose injury qualifies as Federal Family & Medical Leave, be charged Family & Medical Leave while on such worker’s compensation. No substitution is permitted while on worker’s compensation, since the absence is not “unpaid leave.” During the period when the employee receives worker’s compensation benefits, the employee may be offered a “light duty” position. If the employee is placed on “light duty,” the period when the employee is on “light duty” does not count against the employee’s Family or Medical Leave entitlement; the employee retains rights to restoration for a cumulative period of 12 weeks. If the employee chooses to decline the “light duty” job and continues on Medical Leave, the employee may forfeit worker’s compensation benefits.

You are entitled to a copy of this signed authorization. Failure to complete this form may result in a denial or loss of benefits.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_