EMPLOYEE'S REPORT OF INCIDENT AND INJURY
PLEASE PRINT IN INK To be completed by Employee

Employer: **Risk #** **Location**

Name_____ Social Sec. No._____

Home Address_____ Birth Date_____ Sex: ☐ Male ☐ Female

City/State/Zip_____ Telephone: ( )_____

Date of injury **or** onset of symptoms_____ Time_____ ☐ am ☐ pm
Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, write on the back of this form). **Be specific - name any objects or substances involved:**_____
_____
_____
_____

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who?_____

Did you report this incident to anyone? ☐ Yes ☐ No If not, why not?_____

If yes, to whom did you report it?_____ Title/Position_____ When?_____

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):
_____
_____

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull)_____
_____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe:_____
_____

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?_____
Where?_____ If treatment was not sought immediately, explain why: _____
_____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury?
_____ By whom or where?_____
Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury:_____
_____

Medical Release

Under current workers' compensation provisions, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **CompManagement, Inc.** A copy of this form will serve as the original.

Employee Name (print)_____

Employee Signature_____ Date (required)_____

EMPLOYEE'S REPORT OF INCIDENT AND BACK INJURY
To be completed when a back injury is reported
PLEASE PRINT IN INK

Employer:

Name_____ Social Sec. No._____

Home Address_____ Birth date_____ Sex: ☐ Male ☐ Female

City/State/Zip_____ Telephone: ( )_____

Occupation_____ Department_____

What part of your back hurts now?_____

When did you first notice this back pain? Date_____ Time_____ ☐ am ☐ pm

What were you doing at that time (explain **in detail**)?_____

_____

_____

If you were lifting an object, what was it and how heavy?_____

_____

What was your exact position when pain was first noticed? _____

What did you feel?_____

What was the length of time between the injury and your disability, if any?_____

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who?_____

Did you report or mention this injury to anyone? ☐ Yes ☐ No If yes, who?_____ When?_____

Did you ever have a back injury before? ☐ Yes ☐ No If yes, when?_____

What part of your back?_____

Were you ever treated for your back by a doctor? ☐ Yes ☐ No If so, when?_____

Has it given you further trouble since then?_____

Have you ever received or filed for compensation because of a back injury? ☐ Yes ☐ No

Any other injury? ☐ Yes ☐ No If yes, list Bureau of Workers' Compensation claim number(s)_____

_____

Medical Release

Under current workers' compensation provisions, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **CompManagement, Inc.** A copy of this form will serve as the original.

Employee Name (print)_____

Employee Signature_____ Date (required)_____

OCCUPATIONAL DISEASE OR ILLNESS REPORT
PLEASE PRINT IN INK To be completed by Employee

Employer:

Name_____ Social Sec. No._____

Home Address_____ Birth date_____ Sex: ☐ Male ☐ Female

City/State/Zip_____ Telephone: ( )_____

Occupation_____ Department_____

Date of injury or onset of symptoms_____ Time_____ ☐ am ☐ pm

Type of job performed when symptoms first appeared_____

Number of months/years in above job_____

Number of months/years total with this employer_____

Name of your previous employer_____

Did you report or mention your symptoms to anyone? ☐ Yes ☐ No If yes, to whom?_____

What was the length of time between the onset of your symptoms and your disability, if any?_____

Will the condition require further treatment or prevent you from working? ☐ Yes ☐ No If yes, please explain:_____

_____

_____

Date of diagnosis or first treatment for this condition_____ Current diagnosis_____

Doctor's name, address and phone: _____

_____

_____

_____

Have you ever experienced this condition before? ☐ Yes ☐ No If yes, please explain in full detail:_____

_____

Medical visits during the last five years: _____

_____

_____

Current medications prescribed by your doctor(s); include doctor's name:_____

_____

_____

Medical Release

Under current workers' compensation provisions, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **CompManagement, Inc.** A copy of this form will serve as the original.

Employee Name (print)_____

Employee Signature_____ Date (required)_____

STATEMENT OF WITNESS TO ACCIDENT

Employer:

I. INCIDENT IDENTIFICATION INFORMATION

Name of employee alleging incident_____ Shift_____

Occupation_____ Department_____

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your name_____ Your occupation_____

Your address_____ Your telephone number ( ) _____ - _____

_____

Did you see an accident involving the above employee? ☐ Yes ☐ No

If not, how did you learn about the accident?_____

_____

If you did see an accident occur: Date of accident_____ Time of accident_____ ☐am ☐pm

Describe what you saw: _____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Your signature Please print your name Date

State of Ohio §

County of _____ §

Before me, a Notary Public in and for said state, personally appeared the above named who acknowledged before me that he/she did sign the foregoing instrument and that the same is his/her free act and deed.

In testimony whereof, I have hereunto affixed my name and official seal at _____, Ohio this _____ day of _____, 19_____.

(SEAL)

(signed)_____

Name (printed or typed)_____

Notary Public, State of Ohio

My Commission Expires_____(date)

SUPERVISOR'S INVESTIGATION REPORT

Employer:_____
Employee Name:_____ **Soc. Sec. #**_____
Date of Injury:_____

Was an investigation completed concerning the circumstances of this injury? ☐ Yes ☐ No

Were there any witnesses to this injury? ☐ Yes ☐ No
If yes, witness statements should be attached.

Was the injury a result of horseplay? Under the influence of drugs, or purposely self-inflicted? If yes, please specify: ☐ Yes ☐ No

_____
_____
_____

Has there been any recent disciplinary action taken against this employee? ☐ Yes ☐ No
If yes, please describe (and attach any written documentation):

_____
_____

Has the employee missed any work previously due to similar industrial or non -industrial conditions? If so, when? ☐ Yes ☐ No _____

Has the employee submitted medical documentation for the injury? ☐ Yes ☐ No
If so, please attach.

If known, please provide us with the name, address and telephone number of the attending physician:

_____
_____
_____
_____

Has the employee returned to work? ☐ Yes ☐ No
Last day worked_____ Returned to work_____

If not, what is the current estimated date of return?_____

With the information you have, would you recommend the claim be accepted? ☐ Yes ☐ No
If no, why?_____
_____

_____ _____ _____
Employer's signature Title Date

PLEASE ATTACH COMPLETED INCIDENT REPORTS, WITNESS STATEMENTS AND ANY ACCUMULATED MEDICAL BILLS AND INFORMATION. ADDITIONAL COMMENTS MAY BE NOTED ON THE REVERSE SIDE.

MODIFIED DUTY - ATTENDING PHYSICIAN STATEMENT

Claimant_____ Claim No._____ Date of Injury_____

Diagnosis:_____ Employer: _____

Please complete the following items based on your estimated clinical evaluation of this employee. Any item that you do not believe you can answer should be marked "N/A." Modified duty has been developed in conjunction with work-related injuries.

PLEASE RETURN THE COMPLETED FORM TO:

1) Is employee released for full duty? ☐ Yes ☐ No If yes, date released_____

2) If no, please specify for modified duty assignment restriction as follows:

I. In an 8-hour workday, the employee can: (circle full capacity of each activity)

		Continuously	**With rests**
A. Sit	1 2 3 4 5 6 7 8 (hrs)	☐	☐
B. Stand	1 2 3 4 5 6 7 8 (hrs)	☐	☐
C. Walk	1 2 3 4 5 6 7 8 (hrs)	☐	☐

		Never	**Occasionally** (0% to 33%)	**Frequently** (34%-66%)	**Continuously** (67%-100%)
D. Lift:	00-10 lbs.	☐	☐	☐	☐
	11-20 lbs.	☐	☐	☐	☐
	21-50 lbs.	☐	☐	☐	☐
	51-100 lbs.	☐	☐	☐	☐
E. Carry:	00-10 lbs.	☐	☐	☐	☐
	11-20 lbs.	☐	☐	☐	☐
	21-50 lbs.	☐	☐	☐	☐
	51-100 lbs.	☐	☐	☐	☐
F. Bend at waist		☐	☐	☐	☐
G. Squat/crouch/kneel		☐	☐	☐	☐
H. Climb		☐	☐	☐	☐
I. Reach above shoulder level		☐	☐	☐	☐
J. Push/Pull		☐	☐	☐	☐

II. Patient can use hands for repetitive actions such as:

	Simple grasping	**Light pushing/pulling**	**Fine manipulation**
Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Restrictions in effect from _____ to _____ Estimated date of return to full duty_____

Comments_____

_____

_____

_____ _____

Physician Signature Please print name

_____ _____

Telephone Number Date

CompManagement, Inc.