**IMMEDIATELY** contact your supervisor or Orchard Manor’s HR/Payroll Assistant if you are injured on the job, even if you don’t think treatment will be necessary.

Please complete the below report regarding your on-the-job injury and then give it to your supervisor or Orchard Manor’s HR/Payroll Assistant. **If they aren’t available, you must IMMEDIATELY FAX this form to 723-4595.**

Orchard Manor Employee Injury Report

(This form also available on county website [www.co.grant.wi.gov](http://www.co.grant.wi.gov) under County Employee HR Documents; Insurance; Workers’ Compensation)

|  |
| --- |
| Employee Name:  Department:  Employee’s Phone Number: |
| Injury/Incident Date: *\_\_\_\_/\_\_\_\_/\_\_\_\_* Injury/Incident Time: *:* a.m. / p.m.  Shift Start Time: *:* a.m. / p.m. |
| What is your injury?    What were you doing when you became injured?    How did this activity cause the injury?  http://tse1.mm.bing.net/th?&id=OIP.Mb97f390684c2385bbeb2f6629dfefd2bH0&w=221&h=239&c=0&pid=1.9&rs=0&p=0 |
| Part(s) of Body (written description and mark on diagram) |
| Type of injury (pain, abrasion, laceration, burn, hematoma, etc.): |
| If multiple body parts, which one was injured most? |
| Was anyone else present at the time of the incident?  yes or no Name(s): |
| In which wing, room, etc. did the incident occur? |
| Address of Accident Location (if other than Orchard Manor):  Street:  City:  State: |
| Initial Treatment – minor onsite, or list name and address of treatment facility:    ***\*\*\*MSDS sheet must accompany employee to the ER/Urgent Care when treating for contact with chemicals\*\*\*\**** |
| Lost Time: Y / N Since: *\_\_\_\_/\_\_\_\_/\_\_\_\_* at *:* a.m. / p.m. |
| Average Days Work per Week:  Average Hours Work per Week: |
| Date Employer (Dept.) Notified: \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| If the claim is being reported later than 3 days after the incident, explain why: |
| Employee Signature:  Date: *\_\_\_\_/\_\_\_\_/\_\_\_\_*  ***Faxed to Personnel Office by***  ***on***  *\_\_\_\_/\_\_\_\_/\_\_\_\_* ***at*** *:* a.m. / p.m. |

**\*\*IMMEDIATELY\*\* FAX PAGES 1 AND 2 of this form to Grant County Personnel Dept. (608)723-4595**

**DEPARTMENT HEAD OR SUPERVISOR MUST COMPLETE THIS PAGE**

**Employee Information:**

Name of Employee involved in incident / injured:

Date of Incident: \_\_\_\_/\_\_\_\_/\_\_\_\_

Injury/incident reported to me on \_\_\_\_/\_\_\_\_/\_\_\_\_ at       a.m. or p.m.

I witnessed the incident: yes or no

Employee was sent for treatment to: Orchard Manor Nurse; Clinic; ER; Other:

Anticipate lost time: yes or no

for approximately:      hours or      days or      weeks

Do your findings agree with the details on page 1 of this form? yes or no

Explain if “no”:

Can something be done to assist in preventing a related incident in the future? yes or no

Explain both “yes” and “no”:

**Was a resident involved in this incident?**  yes or no Resident(s) Name:

Was the care plan followed? yes or no Explain:

Was proper lift used? yes or no Explain:

Was a resident accident form completed, if necessary? yes or no

**This page completed by (print name):**

on \_\_\_\_/\_\_\_\_/\_\_\_\_ at       a.m. or p.m.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reported to:  Orchard Manor’s HR/Payroll Assistant and/or Grant County Personnel Dept.

by (print name) on *\_\_\_\_/\_\_\_\_/\_\_\_\_* at  a.m. / p.m.

\*\*IMMEDIATELY\*\*

FAX PAGES 1 AND 2of completed form to Grant County Personnel Dept. (608)723-4595

Give the entire form to Orchard Manor’s HR/Payroll Assistant

**SAFETY COMMITTEE MUST COMPLETE THIS SECTION**

Reviewed by (print name)

Remarks:

Reviewer signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Here is the insurance information you will need if you seek medical attention for your on-the-job injury:**

Grant County’s Work Comp Insurance Carrier Orchard Manor - Grant County

Phone Number 800-236-5010 Phone Number (608)723-2113

Claims Mailing Address: Fax Number (608)723-2210

Argent Orchard Manor HR/Payroll Assistant

PO Box 14856 8800 Hwy 61

Lexington, KY 40512-4856 Lancaster, WI 53813

**You must take the below letter and attached “Attending Physicians Report Return to Work Recommendations” form with you to each appointment. The form must be immediately returned to your supervisor**

**Grant County – Workers’ Compensation Return-to-Work Program**

Dear Attending Physician:

Thank you for caring for our injured worker. Grant County is committed to providing a safe, healthful work environment. Please assist us in keeping our employees productively employed while recovering from injury or illness.

It is our experience that the early return of an injured worker to productive modified work is emotionally and physically beneficial to them. EARLY RETURN TO WORK is successful when the injured worker is supported by the physician and Grant County.

Therefore, we will provide safe, meaningful modified work for every injured employee. We will abide by all restrictions you deem necessary to facilitate the healing process.

Our goal is mutual. Your contribution is pivotal.

Please complete the return-to-work form that accompanies this letter. Our employee needs to return this to his/her supervisor immediately after this appointment.

If you need or desire additional information or clarification, please contact the Grant County Personnel Department at (608)723-2540.

Sincerely,



Dawn Mergen

Grant County Personnel Specialist

**\*\*\*Please note that the employee should bring an MSDS sheet to you when treating for contact with chemicals.\*\*\***

Attachment

**ATTENDING PHYSICIANS REPORT RETURN TO WORK RECOMMENDATIONS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Patient's Name (Last) | (First) | | (Middle Initial) | | Date of Injury/Illness | |
|  |  | |  | |  | |
| **TO BE COMPLETED BY ATTENDING PHYSICIAN - PLEASE CHECK** | | | | | | |
| DIAGNOSIS/CONDITION (Brief Explanation) | | | | | | |
|  | | | | | | |
| I saw and treated this patient on \_\_\_\_\_\_\_\_(date) and based on the above description of the patient's current medical problem:  1.  Recommend his/her return to work with no limitation on \_\_\_\_\_\_\_\_\_\_\_(date).  2.  He/she may return to work on \_\_\_\_\_\_\_\_\_\_ (date) with the following limitations: | | | | | | |
| CHECK ONLY AS RELATED TO ABOVE CONDITIONS | | | | | | |
| Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met. | | 1. In an 8 hour work day patient may:  a. Stand/Walk   None  4-6 Hours   1-4 Hours  6-8 Hours   b. Sit  1-3 Hours  3-5 Hours  5-8 Hours   c. Drive  1-3 Hours  3-5 Hours  5-8 Hours  2. Patient may use hand(s) for repetitive:  Single Grasping  Pushing and Pulling   Fine Manipulation  3. Patient may us foot/feet for repetitive movement as in operating foot controls:   Yes  No  4. Patient may: Not at All Occasionally Frequently  Bend     Twist     Squat     Climb    Reach | | | | |
| Lifting 25 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls. | |
| Lifting 30 pounds maximum with frequent lifting and/or carrying of object weighing up to 20 pounds. | |
| Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds. | |
| Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds. | |
| Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds. | |
| OTHER INSTRUCTIONS AND/OR LIMITATIONS INCLUDING PRESCRIBED MEDICATIONS | | | | | |
|  | | | | | |
| 3.  These restrictions are in effect until \_\_\_\_\_\_\_\_\_(date) or until patient is reevaluated on \_\_\_\_\_\_\_\_\_(date)  4.  He/she is totally incapacitated at this time. Patient will be reevaluated on \_\_\_\_\_\_\_\_\_(date)  5.  Referred To: None  Private Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Doctor)  Return Here \_\_\_\_\_\_\_\_ \_\_\_\_\_\_(date/time)  A Consultant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Doctor/date/time) | | | | | |
| Physician's Signature | | Date Signed | | | |
| Physician’s Printed Name | | Physician/Clinic’s Phone Number | | | |
| **AUTHORIZATION TO RELEASE INFORMATION** | | | | | |
| I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer to his representative. | | | | | |
| Patient's Signature | | | | Date | |

**Fax completed form to Orchard Manor’s HR/Payroll Assistant (fax 608-723-2210)**

**Give patient a copy of this form to immediately return to their supervisor.**