IMMEDIATELY contact your supervisor or HR/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 HR/Assistant. **If they aren't available, you must IMMEDIATELY FAX this form to 723-4595.**

Grant County Employee Injury Report

(This form also available on county website www.co.grant.wi.gov under County Employee HR Documents; Employee Forms; Workers Compensation Injury/Incident Form)

Employee Name: _____ Department:_____

Phone Number: _____

Injury/Incident Date: ____/____/____ Injury/Incident Time: _____:_____ ☐a.m. / ☐p.m.

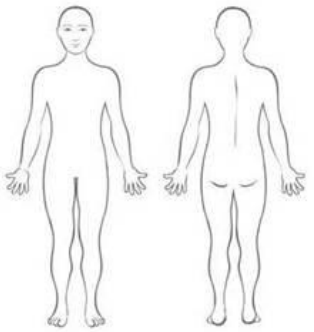
Shift Start Time: _____:_____ ☐a.m. / ☐p.m.

What is your injury?

What were you doing when you became injured?

How did this activity cause the injury?

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):_____

Where did the incident occur? If Orchard Manor, include what wing you were in

Address of Accident Location:

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 Human Resources 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: ☐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/patient/inmate involved in this incident? ☐yes or ☐no
Resident/Patient/Inmate(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: ☐ Supervisor/HR/Assistant and/or ☐Grant County Human Resources Dept.
by (print name)_____ on ____/____/____ at _____ ☐a.m. / ☐p.m.

IMMEDIATELY
☐FAX PAGES 1 AND 2 of completed form to Grant County Personnel Dept. (608)723-4595
☐Give the entire form to your Supervisor/HR/Assistant

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
Phone Number 800-236-5010
Claims Mailing Address:
Argent
PO Box 14856
Lexington, KY 40512-4856

Grant County Human Resources
Phone Number (608)723-2540
Fax Number (608)723-4595
111 S Jefferson Street
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 Human Resources Department at (608)723-2540.

Sincerely,

Grant County Human Resources

*****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.

☐ 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.

1. In an 8 hour work day patient may:
   a. Stand/Walk
   ☐ None ☐ 1-4 Hours ☐ 4-6 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	☐	☐	☐

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 Human Resources (fax 608-723-4595)**

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