### ATTENTION ALL EMPLOYEES

# **NORWALK CSD**

## **Workers' Compensation Medical Treatment**

**EFFECTIVE: Immediately** 

If you are injured at work, you must immediately report the incident to your supervisor.

NORWALK CSD has designated the following medical clinics to treat all workplace related injuries/illnesses. If you need medical treatment due to a work-related injury or illness, seek treatment at:

#### MERCY OCCUPATIONAL HEALTH

1055 JORDAN CREEK PKWY, STE 100 WEST DES MOINES, IA 50266 (515) 358-5950 PH (515) 358-5951 FAX

#### UNITYPOINT FAMILY MEDICINE

801 COLONIAL CIRCLE NORWALK, IA 50211 (515) 285-3200 PH (515) 285-3232 FAX

**EMERGENCY CARE:** For a LIFE THREATENING or SERIOUS INJURY, call 911 immediately and seek immediate treatment at the nearest emergency facility. Hospitals include, but are not limited to:

MERCY MEDICAL CENTER

1111 6<sup>TH</sup> AVENUE DES MOINES, IA 50314 (515) 247-3121 PH IOWA METHODIST MEDICAL CENTER

1200 PLEASANT STREET DES MOINES, IA 50309 (515) 241-6212 PH

#### **PLEASE NOTE**

If you choose to be treated by any other medical facility and/or physician, you may not qualify for any workers' compensation insurance benefits and you may be responsible for all medical costs related to this incident. This is in accordance with your state's Workers' Compensation statute.

If you have any questions, please contact Teresa Williams at (515) 981-0676, ext. 4015.



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I verify that I have received NORWALK CSD'S Workers' Compensation Medical Treatment information.			
Employee's Signature (PRINTED)			
Employee's Signature	Date		

## **Employee's Work Injury Report**

The injured employee is responsible for answering all questions on the Employee's Work Injury Report accurately and in detail. This will make the processing of your claim both accurate and timely. This completed report should be given to the workers' compensation contact within 24 hours of your work-related injury.

THIS FORM DOES NOT REPLACE THE FIRST REPORT OF INJURY (FROI). EMPLOYER COMPLETES THE FROI.

THE FROI IS REQUIRED BY THE STATE TO INITIATE A WORKERS' COMPENSATION CLAIM.

Name	Social Security Number				
Address	Birth Date		Sex	М	F 🗌
City, State	Zip	Telephone			
Married ☐ Single ☐ Number of Dependents		Home/Scho	ol		
Family Physician	Telephone Number				
		#(HICN)			
Have you applied for Medicare or SSDI? N \( \subseteq \text{Y} \subseteq \)	Pending Rejecte	ed 🗌			
Job Title	Employment Date				
Salary/Hourly Rate	<del></del>				
Building Location	Time Work Day Begins				
Date of Injury	Time of Accident				
Where in the facility/job site did this injury occur?					
What were you doing when injured?					
How did the injury occur?					
Describe the injury or illness in detail and indicate the part of the body affected. (Designate right or left if appropriate.)					
Any previous similar injury? If yes, explain.					
Was this injury witnessed? If so, by whom?					
Did you lose time from work? Yes ☐ No ☐	Date(s) missed				
Have you returned? Yes ☐ No ☐	If yes, what was the date	?			
Medical Facility					
Diagnosis/Care Prescribed					
When you return to work, you must call Teresa Williams at (515) 981-0676, ext. 4015 and your assigned claims adjuster.					
Employee's Signature					
Employee's Signature (PRINTED)	Da	te			

## SUPERVISOR'S INSTRUCTIONS

## **Assisting the Injured Employee**

- 1. An employee who is injured at work must immediately report the incident to their supervisor.
- 2. The supervisor is required to:
  - Obtain immediate medical attention for the injured worker: Call the physician or medical facility prior to the employee's arrival, alert the staff of the injury/illness and approximate arrival time;
  - Follow company requirement for reporting job related injuries and illnesses;
  - Complete an incident investigation report.
- 3. The supervisor and injured worker review information received from the doctor and jointly determine if appropriate work is available.
- 4. Following an injured workers' return to work, the supervisor or the workers compensation contact monitors the injured workers' progress to assure that restrictions are carefully followed and assist to resolve any difficulties.
- 5. The injured worker must immediately report any difficulties with performing assigned work. Supervisor and injured worker work to address the problem.

## The Investigation Report

The purpose of this form is to determine what actions are needed to eliminate or control the hazards that have caused the accident. The information gathered will guide your staff in developing safety consciousness and knowledge of safe conditions and safe work methods. If you are not aware of the circumstances surrounding the injury, you should consult with the employee in order to complete the investigation report accurately.

The statements made in this report are very important and should not contain phrases as "Employee should be more careful." As the supervisor, you should make the appropriate corrective recommendations for each accident such as "Notified the appropriate employee to place caution signs in the area when floors are wet."

After you complete the investigation report, return it to the workers' compensation contact within 24 hours of the employee's work-related injury.

If you have any questions or concerns, please call Teresa Williams at (515) 981-0676, ext. 4015.

## SUPERVISOR'S INVESTIGATION REPORT

Name of Injured Employee:	Date:		
Job Title and Department:			
The and Department.			
Date and Time Of Injury:	Type of Injury:		
Medical Treatment Center:			
Wedical Freatment Center.			
What was the employee doing when injured? Where in the facility / job site did the accident happen?			
Describe what happened:			
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What corrective steps will be done (or could be done)	to prevent recurrence?		
Was the employee working at designated job?	☐ Yes ☐ No		
Is there modified duty available for the injured worker			
Has the injured employee returned to work?	Yes No If so, what date?		
Supervisor's Signature	Date		
Reviewed by Workers' Compensation Coordinator	Date		
Comments:			

Return completed form within 24 hours of the accident to Teresa Williams

# PHYSICIAN AUTHORIZATION FORM FOR MEDICAL TREATMENT

Injured Employee's Name:	Date:				
Company Name & Address:  NORWALK CSD POLICY # 9H58910	Supervisor:				
380 WRIGHT ROAD					
NORWALK, IA 50211-1661					
Do Not Use Your Group Health Membership Car	d if this injury/illness				
was sustained while working or acting in an official cap	• •				
The following facilities are the designated workers' compensation treatment co	•				
Form with you will assist the staff in your care and in processing your med					
someone call for you to let the physician or clinic know you are on your way njury or illness.	for medical treatment and the nature of the				
	AMILY MEDICINE				
1055 JORDAN CREEK PKWY, STE 100 801 COLONIAL WEST DES MOINES, IA 50266 NORWALK, IA :					
(515) 358-5950 PH (515) 285-3200 (515) 358-5951 FAX (515) 285-3232					
(616) 266 65611780					
EMERGENCY CARE: For a LIFE THREATENING or SERIOUS INJURY, cal	911 immediately and seek immediate				
treatment at the nearest emergency facility.					
Send all EMC work comp medical hills di	irectly to:				
Send all EMC work comp medical bills directly to: EMC Insurance Companies, P.O. Box 884, Des Moines, IA 50306 Fax: 888.992.8214					
PLEASE NOTE					
If you choose to be treated by any other medical facility and/or physician, you may not qualify for any workers' compensation insurance benefits and you may be responsible for all medical costs related to this incident. This is in					
accordance with your state's Workers' Compensation statute.					
If you have any questions, please call Teresa Williams at (515) 981-0676, ext. 4015.					
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Supervisor's Signature	Date				



## Work Related Injury/Illness Report

	PLEASE FAX IMMEDIATELY TO BOTH.			
Date of Service:	NORWALK CSD Fax: (515) 981-0559			
Patient Name:	EMC Insurance Companies Fax: (888) 992-8214			
Employer: NORWALK CSD	Notified: Yes No			
Diagnosis: Is condition work related?				
Treatment Plan:				
Medication(s):				
Date of most recent examination by this office:/ The n	ext scheduled visit is: as needed OR//.  Month/Day/Year			
1. Recommended his/her return to work with no limitations on	•			
2. He/She may return to work on with the following limit	itations.			
DEGREE	LIMITATIONS			
<ul> <li>Sedentary Work. 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.</li> <li>Light Work. Lifting 20 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.</li> <li>Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds.</li> </ul>	In an 8 hour work day, patient may:  a. Stand/Walk None			
Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.	4. Patient is able to:  Frequently Occasionally Not at all  a. Bend □ □ □			
<ul> <li>Very Heavy Work. Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.</li> </ul>	b. Squat			
OTHER INSTRUCTIONS AND/OR LIMITATIONS:				
3. These restrictions are in effect until or until patient is reevaluated.				
4. He/She is totally incapacitated at this time. Patient will be reevaluated on  Date				
Treating Facility Name:				
Please Print				
Physician's Signature:	Phone No: ()			
RELEASE OF INFORMATION AUTHORIZATION				
I authorize the treating physician to release copies of my medical records including lab and x-ray reports to the above-named employer and the insurance company. I certify that I have received a copy of this report.				
Employee's Signature:	Date:			