City of De Pere
Employee Instructions For Completing
Report of Injury, Exposure, or Illness

1. Report your work-related injury immediately to your supervisor.

2. Complete the Report of Injury Report (page 3) prior to the end of your work shift of the day of injury.

3. Complete Bloodborne Pathogen Exposure Incident Sheet (page 4), if applicable to exposure.

4. After completing the Report of Injury Report, turn the ENTIRE PACKET into your immediate supervisor excluding employee instructions (this page) and the important information if you seek treatment page. If submitting electronically, all pages will be submitted. Please print these instructions and important information if you seek medical treatment for your records.

5. If necessary, consult medical treatment. Bring the attached Work Related Injury/Illness Report with you. If needed you may contact Human Resources at (920) 339-4045 to obtain the necessary workers' compensation claim number to give to the provider.

6. When seeking medical treatment, report to medical provider that incident is a work-related injury. Please let your provider know that the City of De Pere has light-duty available for employees injured at work. If medical provider has questions they should contact the Human Resources at (920) 339-4045.

7. Request a legible work restriction document from medical provider when seeking medical treatment. You may ask the provider to complete the attached Work Related Injury/Illness Report. Turn in to your supervisor **and** Human Resources as soon as possible after your medical appointment.

The following medical facilities are the preferred workers' compensation treatment centers. If you need medical treatment due to a work related injury or illness, seek treatment at:

BELLIN HEALTH Occupational Medicine: (920) 430-4560 Urgent Care: 920-433-6000		**PREVEA** Prevea Urgent Care**:** (920) 496-4700Prevea Occupational Health: (920) 405-1420 *Please call ahead as appointments are needed.*		
3263 Eaton Road Green Bay, WI 54311	1630 Commanche Avenue Green Bay, WI 54313	*Occupation Health* 2502 S Ashland Ave Green Bay, WI 54304	*Urgent Care* 3860 Monroe Road De Pere, WI 54115	*Urgent Care* 1601 Lawrence Drive De Pere, WI 54115
NOTE: Use of the provider listed is voluntary and choosing to use an alternate provider that is not listed will not affect your employee benefits under state workers' compensation laws.				

For a SERIOUS INJURY OR ILLNESS (or any treatment that should not wait until clinic hours the next day) seek immediate treatment at the nearest emergency facility. Hospitals include, but are not limited to:

BELLIN MEMORIAL HOSPITAL 744 S WEBSTER AVE GREEN BAY, WI 54301 (920) 433-3500	**ST. MARYS HOSPITAL** 1726 SHAWANO AVE GREEN BAY, WI 54303 (920) 498-4200	**AURORA BAYCARE MEDICAL CENTER** 2845 GREENBRIAR RD GREEN BAY, WI 54311 (920) 288-8000	**ST. VINCENT HOSPITAL** 835 S VAN BUREN ST GREEN BAY, WI 54301 (920) 433-0111

EMPLOYEES PLEASE KEEP THIS PAGE!!

IMPORTANT INFORMATION IF YOU SEEK TREATMENT

Whether you are seeking treatment now or later, to ensure you have the information your provider may request, you should keep the detachable card in your wallet.

If you are seeking medical attention for a work related injury or exposure, your provider should send invoices directly to EMC Insurance company at PO Box 327; Brookfield, WI 53008-0327 or via fax at 1-888-992-6125 or email at Milwaukee.Claims@EMCIns.com. Your provider may ask for your claim number. If you have not received your claim number yet, you may contact Human Resources at 339-4045 to obtain it. *Please note:* It may take a day or two following the injury for Human Resources to be sent the claim number.

Following your medical appointment, please ensure you have received a completed Work Related Injury/Illness Report (attached in the Workers Compensation packet or available from Human Resources). The return to work should list your restrictions, if any, and the duration of the restrictions. A copy of the Work Related Injury/Illness Report or return to work should be given to your supervisor AND Human Resources immediately following your appointment.

Questions about the Workers' Compensation process or your role and responsibilities? There is a list of frequently asked question available on the Human Resources webpage under Current City of De Pere Employees.

CITY OF DE PERE

Claim Number: _____

Work related injury invoices can be mailed, faxed or e-mailed directly to EMC:

EMC Insurance Companies
PO Box 327
Brookfield, WI 53008-0327
E-mail: Milwaukee.Claims@EMCIns.com
Fax: 1-888-992-6125

City of De Pere
Report of Occupational Injury, Exposure, or Illness

EMC Fax #: 1-888-992-6125

IMPORTANT NOTE:
This form needs to be completed before the end of the shift in which the incident occurred. All questions must be answered; missing information may delay your Workers' Compensation Claim.

Name of Injured Employee: Social Security Number (required):	Employee's Complete Home Address (including city and zip code):	
Work Number: Home/Cell Number:	Gender: Male ☐ Female ☐	Date of Birth:
Job Title:	Date of Hire:	
Department: ☐ City Hall ☐ Fire Department ☐ Parks, Recreation & Forestry ☐ Police Department ☐ Public Works– Clerical ☐ Public Works– Engineering ☐ Public Works– Streets ☐ Public Works– Water	Date and Time of Incident:	
Type of Incident: ☐ Injury ☐ Illness ☐ Exposure	Time Shift Started:	
Specifically, where did the incident occur:		
Specifically, describe the nature and extent of your incident (For example: tripped and fell; pain in left shoulder):		
List Personal Protective Equipment you were wearing at the time of the incident:		
List any witnesses to the incident:		
Name of Person Notified:	Date Notified:	
Have you sought medical treatment? ☐ Yes ☐ No	Have you lost any work time? ☐ Yes ☐ No *(Not including the day of the injury)*	
Date and time of initial medical treatment:		
Name of attending physician:		
Name of hospital or medical center: Address: Phone Number:		
Contact Name: Tracy Hood, Human Resources Generalist	(920) 339-4045 or deperehr@mail.de-pere.org	
Occupation Code: ___/___/___/___	**Activity at time of Accident** ___/___/___/___	**Accident Location:** ___/___/___/___
Employee Signature	Date Form was signed by Employee:	
Date Form Was Faxed to EMC:	Date Form & Fax Transmittal Sheet was forwarded Human Resources:	

Form Revised: January 2020

Complete next page before emailing if you had a bloodborne pathogen exposure.

Email

City of De Pere
Complete Only For Bloodborne Pathogen Exposure Incidents
Exposure Information

If there is a potential exposure, follow the source person to the hospital/doctor's office. If unable to follow the source person, go to the doctor's office during normal business hours or the emergency room after normal business hours. Report the exposure and the doctor will determine if there has been a true exposure.

Employee Name _____

This form is to only to be used to report an exposure to a bloodborne pathogen.

Route: (please check all that apply)

☐ Eyes ☐ Non-Intact Skin ☐ Needle/syringe

☐ Nose ☐ Mouth ☐ Other

☐ Bite ☐ Scratch

Estimated amount and type of fluid exposed to, if known:

Was area cleansed/flushed ? Describe:	☐ Yes	☐ No
Was personal protective equipment (PPE) used?	☐ Yes	☐ No
Did PPE fail? e.g., was glove torn?	☐ Yes	☐ No
Was clothing contaminated?	☐ Yes	☐ No
Clothing sent for cleaning? If yes, where and date:	☐ Yes	☐ No If no, why:
Exposure treatment/testing initiated? If yes, list medical provider and date:	☐ Yes	☐ No

Other information:

WORK RELATED INJURY/ILLNESS REPORT

Date of Service: _____

Patient Name: _____

Employer: City of De Pere

PLEASE FAX IMMEDIATELY TO BOTH:

City of De Pere/HR (Company Name) Fax (920) 339-4049

EMC Insurance Companies Fax (888) 992-6125

Notified: ☐ Yes ☐ No

Diagnosis: Is condition work related? ☐ Yes ☐ No

Treatment Plan:

Date of most recent examination by this office: ____/____/_____. The next scheduled visit is: ☐ as needed OR ____/____/_____.
Month/Day/Year Month/Day/Year

1. ☐ Recommended his/her return to work with no limitations on _____.
Date

2. ☐ He/She may return to work on _____ with the following limitations.
Date

DEGREE

☐ **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.

☐ **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.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds.

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Very Heavy Work.** Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.

LIMITATIONS

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 hands for repetitive:
   ☐ Single Grasping
   ☐ Pushing & Pulling
   ☐ Fine Manipulation

3. Patient may use feet for repetitive movement as in operating foot controls: ☐ Yes ☐ No

4. Patient is able to:

	Frequently	Occasionally	Not at all
a. Bend	☐	☐	☐
b. Squat	☐	☐	☐
c. Climb	☐	☐	☐

OTHER INSTRUCTIONS AND/OR LIMITATIONS:

3. ☐ These restrictions are in effect until _____ or until patient is reevaluated.
Date

4. ☐ He/She is totally incapacitated at this time. Patient will be reevaluated on _____.
Date

THIS TREATMENT HAS BEEN DISCUSSED WITH THE EMPLOYEE

Treating Facility Name: _____
Please Print

Physician's Signature: _____ Phone No: (_____) _____

6410

City of De Pere
Supervisor Instructions For Completing And Reporting
Report of Injury, Exposure, or Illness

☐ Injured employee completes the Report of Injury Report prior to the end of their work shift of the day of injury. If employee cannot fill out the form, the supervisor should fill it out. If injury/exposure causes a need for inpatient hospitalization and/or is life threatening contact the department head and Human Resources Director at 339-4045 or 621-9236.

☐ Ensure employee has the Work Related Injury/Illness Report form. Remind employee that they need to have the provider complete the form if they seek medical treatment and that the City offers light-duty for employees injured at work.

☐ **Inform Human Resources as soon as possible if the employee seeks medical treatment or misses any work due to the injury**. If an employee is authorized off of work, Human Resources may follow up with the provider to ensure they know light-duty is available and the employee is returned to work as soon as possible.

☐ Supervisor faxes FRONT page of Report of Injury Report immediately to: **EMC Fax #: 1-888-992-6125.** If all areas on the Report of Injury Report are not complete, fax in the form (no cover sheet necessary) with as much information as possible.

☐ Print off the fax confirmation after documents are sent via fax to EMC.

☐ Complete the Supervisor's Accident Investigation form.

☐ Forward all forms (entire packet & fax confirmation) to the department head or designee (if applicable). Department head must sign off on the supervisor accident investigation form.

☐ Department head sends originals (make copies for department if desired) of all forms (entire packet and fax confirmation) to Human Resources.

Make certain the employee gives you a legible work restriction document after returning from his/her medical appointment. This work restriction can be faxed to Human Resources, 339-4049, emailed, or hand-delivered as soon as possible. The employee should provide a return to work after EACH visit to the provider, with the exception of physical therapy appointments.

The following medical facilities are the preferred workers' compensation treatment centers. If the employee needs medical treatment due to a work related injury or illness, seek treatment at:

BELLIN HEALTH Occupational Medicine: (920) 430-4560 Urgent Care: 920-433-6000		**PREVEA** Prevea Urgent Care**:** (920) 496-4700Prevea Occupational Health: (920) 405-1420 *Please call ahead as appointments are needed.*		
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744 S WEBSTER AVE GREEN BAY, WI 54301 (920) 433-3500	1726 SHAWANO AVE GREEN BAY, WI 54303 (920) 498-4200	2845 GREENBRIAR RD GREEN BAY, WI 54311 (920) 288-8000	835 S VAN BUREN ST GREEN BAY, WI 54301 (920) 433-0111

City of De Pere - Supervisor's Accident Investigation
Loss Source Identification

When Date/Time of Accident _____ Report to supervisor or first aid delayed Yes _____ No _____ If yes, why? _____

Who Injured Person's Name_____ Department_____

Job Title: _____

Injury/Loss Nature/extent of injuries. Include parts of the body and medical treatment administered.

_____

_____

Where Exact location where accident occurred

_____

_____

What/How Type of accident (use code from below) Injury (1-10) _____

Accident Code (Check all that apply)

Injury

1. Fall from elevation
2. Fall same level
3. Struck by
4. Caught in, under, or between
5. Overexertion
   - Push/pull
   - Lift/lower
   - Carry/hold
6. Cumulative trauma disorder
7. Electrical contact
8. Fumes, dust, gas, caustics, noise, etc.
9. Motor vehicle
10. Other (describe): _____

Was employee doing something other than required duties at time of accident? Yes_____No_____

If yes, what and why?_____

_____

Was a safety policy or procedure violated? Yes_____No_____

If yes, please explain: _____

Description of accident: What employee was doing; how he/she was doing it; and any physical object including weights, tools, machines, structures, or equipment involved.

_____

_____

_____

Why Check accident causes and comment fully here.

_____

_____

Prevention

What should be done and by whom to prevent recurrence of this type of accident? Include target dates:

_____

_____

_____

What action are you taking to see that this is done? Include target dates and responsible party.

_____

_____

_____

Accident Cause Analysis
(check all that apply)

ENVIRONMENTAL

___ **Inadequate safeguards**
Lack of handling or safety devices, unsafe design; unguarded machinery, lack of safe work

___ **Improper or defective equipment**
Poorly maintained, broken, cracked, rough, slippery, worn equipment, inappropriate personal protective equipment

___ **Location hazards**
Poor layout; congestion; insufficient space for storage; poor lighting, etc.

___ **Poor ergonomics**
Heavy lifting, poor workstation design; excessive bending, twisting or reaching; inadequate tools

___ **Poor housekeeping**
Improper piling or placing; clutter, spillage or breakage

___ **Not otherwise classified**

PERSONAL

___ **Bodily conditions**
Physical impairment; illness; fatigue, emotional upset; intoxication

___ **Lack of skill or knowledge**
Improperly trained; inexperienced; uninformed; unaware, etc.

___ **Adequate skill or knowledge but failure in execution**
Chance-taking; unauthorized or unnecessary use of equipment or tools; failure to use or deliberately making safety or control devices ineffective; failure to do what should have been done in the particular situation

___ **Improper apparel**
Failure to use personal protective equipment (eye, face, foot, hand, head, hearing, respiratory, etc.,): loose clothing, jewelry, etc.

___ **Not otherwise classified**

Supervisor's Signature _____ **Date** _____

Dept. Head Comments _____

_____

Dept. Head Signature _____ **Date** _____

Email to Supervisor

Email to Human Resources