WOOD COUNTY, OHIO
Workers' Compensation/PERRP
Accident/Injury Investigation Report

In order to comply with the Wood County Workers' Compensation Policy, the following report shall be completed immediately or by the end of the employee's work shift for every injury, regardless of treatment, and submitted to the Wood County Commissioners' Office.

COMPLETE ALL SECTIONS

EMPLOYEE INFORMATION:

Date _____

Employee Name_____ SS# _____

Home Address _____ Phone ___

_____

Date of Birth _____ Sex (M/F) _____ Married (S/M) _____ Date of Hire _____

Department _____ Work Days _____ Shift _____

Job Title _____ Date Beginning Job Title _____

TIME AND PLACE OF ACCIDENT:

Date of Accident/Injury or illness _____ Day of Week _____ Time_____ am pm

Time Shift Started_____ am pm Working Overtime? Yes ( ) No ( )

Date Last Worked _____ Date Returned to Work_____

Accident Location including address: _____

_____

ACCIDENT DETAILS:

Type of Accident (vehicle, fall, etc.) _____ Were you injured? Yes ( ) No ( )

What was the employee doing just before the incident occurred? Describe the activity. _____

_____

_____

What happened? Tell how the injury occurred. Be specific. (Use separate sheet for additional space.)

_____

_____

_____

_____

Name of Witness(es) _____

_____

PLEASE ATTACH STATEMENTS OF WITNESS(ES) IF APPLICABLE

Were other people injured? Yes ( ) No ( ) Names _____

If accident/injury involved County vehicle/equipment, complete an "Incident Report".

PREVENTATIVE ACTION:

What could be done to prevent similar accidents? _____

_____

INJURIES:

What was the injury or illness? Tell the part of the body that was affected and how it was affected.

	Part of Body	Nature of Injury
1.	_____	_____
2.	_____	_____
3.	_____	_____

Name the object or substance that injured the employee _____

TREATMENT:

Name of Physician or other health care professional: _____

If treatment was given away from the worksite, where was it given?_____

_____

Treatment Date _____ Follow-up treatment date _____ Time _____

Did you receive first aid treatment at work or hospital? Yes( ) No( ) Taken to Hospital? Yes( ) No( )

Admitted to Hospital? Yes( ) No( ) Did Employee die? Yes( ) No( )

Return to work date: _____ Work restrictions? Yes ( ) No ( )

Supervisor's signature must be on this form for further processing.

IF ANYONE KNOWINGLY PROVIDES INACCURATE INFORMATION OR MAKES A FALSE ALLEGATION OF AN INDUSTRIAL INJURY, THEY MAY BE SUBJECT TO CRIMINAL AND/OR CIVIL PROSECUTION UNDER THE REVISED CODE OF OHIO. FALSIFICATION OF INFORMATION WILL RESULT IN DISCIPLINARY ACTION.

Medical Release of Information

As provided by OHIO REVISED CODE SECTION 4123.651(c). Under current workers' compensation law, 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 and/or to CompManagement, Inc. (representative of employer). A photocopy of this release shall be effective as the original. This consent shall be valid no longer than is reasonably necessary to accomplish the purpose for which it was given or to expire upon final disposition of my industrial claim.

_____ _____

Employee's Signature Date Supervisor's Signature Date

All reports for accident/injuries must be submitted to the address below:

Assistant HR Manager
Wood County Commissioners' Office
One Courthouse Square
Bowling Green, OH 43402

COPY TO APPOINTING AUTHORITY OR DEPARTMENT HEAD

PERRP No. _____

BASIC INFORMATION FOR EMPLOYEES
WORKERS' COMPENSATION BENEFITS
AND INSTRUCTIONS FOR FILING A CLAIM

I The Ohio Bureau of Workers' Compensation (BWC) provides employees with the following benefits for work related injuries and illnesses:

A. **Payment of medical care** including prescriptions, provided by a clinic, physician, hospital or medical services, for the work related injury or condition as approved by the Bureau of Workers' Compensation, Industrial Commission of Ohio or Managed Care Organization (MCO). The MCO will pay the usual, customary and reasonable medical fees determined by the BWC fee schedule.
B. **Payment of compensation** for disability after seven or more calendar days lost from work. No compensation shall be allowed for the first week after an injury is received and no compensation shall be allowed for the first week of total disability, whenever it may occur, unless and until the employee is totally disabled for a continuous period of two weeks or more, in which event compensation for the first week of total disability, whenever it has occurred shall be paid. Employees can not receive compensation for lost wages from the BWC and Wood County at the same time.
C. **Death benefits**, payable to the beneficiaries of any employee whose death is a direct result of a work related accident or illness.

II **Employees shall report all accidents and injuries immediately** to their supervisor or prior to the end of the employee's work shift and should seek appropriate medical attention if necessary. Supervisors must immediately notify the Assistant HR Manager in the Commissioners' office of all employee workplace accidents/injuries. For all work related injuries or illnesses, some or all of the following forms may be required:

A. **Accident/Injury Investigation Report:** Used by employees to report **all** accidents/injuries and names of witness(es), regardless of medical attention, to the employee's office Workers Compensation representative and Assistant HR Manager.
B. **First Report of an Injury, Occupational Disease or Death form (FROI):** Used by employee, medical provider and employer to report all injury, occupational disease, or death claims to the Bureau of Workers' Compensation.
C. **Physician's Report of Workability:** Used by the medical provider to report the injured worker's ability to return to work.
D. **Salary Continuation Agreement:** Used by the employee and Commissioners' Office when an employee may receive wages for a lost time claim from Wood County instead of the BWC.

All forms shall be forwarded to the Commissioners' Office as required by the Workers' Compensation policy and procedure for consideration and copies kept on file in the employees' office/department. Failure to complete pertinent information may result in a delay in processing the claim.

III **For all work related injuries or illnesses that require medical care**, the injured worker is encouraged to seek treatment from the County's preferred medical provider, Employer Services at Falcon Health or a participating provider offered within the BWC certified provider network. A search for BWC certified providers is available at www.bwc.ohio.gov. ***(Reimbursement to a non-certified provider will only be provided as an emergency or initial treatment.)***

A. Employees must notify the provider of their employer and MCO, which is Sedgwick Managed Care.
B. The MCO will review the treatment recommended by the provider and authorize appropriate treatment for the allowed conditions in the claim.
C. Immediately following treatment from a work related injury, employees are required to submit a **Physician's Report of Workability** form with a doctor's release to their office's Workers' Compensation representative. This information shall be forwarded to the Assistant HR Manager in the Commissioners' Office to be filed with the BWC.
D. Initial prescriptions for a work related injury without a BWC claim number assigned yet can be filled at the pharmacy when the treating provider writes "Work Related Injury" on the prescription. Subsequent prescriptions for conditions related to an allowed work related injury can be filled at the pharmacy using the injured workers BWC claim number. Only drugs in the BWC formulary will be covered. A drug formulary look up is available at www.bwc.ohio.gov.
E. Providers are required to notify the employee's MCO within 24 hours of initial treatment.

IV The medical provider or MCO will forward the information to the BWC who will assign a claim number and send the claim number notification to the employee's home address. **It is the employee's responsibility to notify all service providers of his/her claim number so they may bill the MCO.** In the State of Ohio, the submission of medical bills associated with a Workers' Compensation claim is ultimately the responsibility of the injured worker. The assignment of a claim number by the BWC is only an acknowledgment of the claim.

V Wood County has implemented a **Transitional Work Program (TWP) Policy** in order to return employees with a work related injury to gainful employment in a temporary bridge assignment, within the limitations of the injury. Work tasks will be assigned based on the capabilities determined by the treating physician. Employees participating in TWP will retain their current rate of compensation and benefits while recovering from their work-related injury/illness.

A. The Workers' Compensation physician will evaluate the injured worker for return-to-work parameters, i.e.; ability to perform his/her current position based on the classification with slight modification, or approval of a bridge assignment considering his/her injury. Employees that refuse to accept a physician approved assignment may jeopardize payment of compensation being awarded by the Bureau of Workers' Compensation.

B. The injured worker will receive a briefing by the supervisor or the Assistant HR Manager on the Transitional Work Program (TWP) policies and procedures including a written description, verbal instructions, and photographs. The employee must respond by signing and returning the Transitional Work Agreement after receipt. Please refer to the Transitional Work Program Policy & Procedures for further information.

C. Employees performing Transitional Work must be seen by the Workers' Compensation Physician at intervals designated by the physician for reevaluation of assignments to coincide with recovery and ability to work progressively more demanding job duties. A copy of all Physician's Report of Workability shall be forwarded to the Assistant HR Manager in the Commissioners' Office for further processing.

VI Insurance benefits for employees on a lost time claim will continue for up to sixty (60) days, after the last day the employee was actively at work. The Employee shall continue to be responsible for any co-payments required by the plan.

VII Employees on a Workers Compensation claim that are unable to work may qualify for benefits under the Family Medical Leave Act (FMLA). Benefits provided to employees under the Workers' Compensation policy and FMLA commence on the same date.

VIII Please refer to the Workers' Compensation Policy & Procedures for further information. For information on filing or status of a claim, contact your supervisor or the Assistant HR Manager in the Commissioners' Office at 354-9100.

Bureau of Workers' Compensation

Physician's Report of Work Ability (MEDCO-14)

Instructions

- Use this form to provide detailed information about the injured worker's ability to work. Add comments to Section 4 or attach additional information as necessary. BWC uses the information to support a request for temporary total compensation.
- The treating physician must submit this form each time they see the injured worker unless they:
  - Have been awarded permanent and total disability.
  - Have returned to work without restrictions within seven days of the injury.
  - Are being treated after the treating physician has released them to their former position of employment (i.e., full duty job) held on the date of injury without restrictions.
- While you may use an equivalent physician-generated document (e.g., office notes, treatment plan) to the MEDCO-14, it must contain, at a minimum, the required data elements. If you've previously submitted equivalent data, indicate the date of the report on the form (e.g., 5/15/2021, office note).

Note: Physician assistants and nurse practitioners may complete this form; however, they may only certify temporary disability for the first six weeks after the date of injury. Subsequent periods of temporary disability require a co-signature by the treating physician.

- Fax form to the managed care organization if the employer is state-fund or to the employer if self-insured.
- **Important:** Failure to provide complete information may delay compensation payments to the injured worker.

Injured worker name	Claim number	Date of injury

Date of ***last*** appointment/examination	Date of ***this*** appointment/examination	Date of ***next*** appointment/examination

1 Submission type (Select one of the options below.)

☐ Initial MEDCO-14. ***Proceed to Section 2.***
☐ Subsequent MEDCO-14, **no** changes ***Proceed to Section 6.***
☐ Subsequent MEDCO-14, **with changes.** Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.

2 Job description and work status ☐ Reporting changes from last evaluation ☐ No changes

- Have you reviewed the injured worker's job description? ☐ Yes ☐ No
  - **If yes,** who provided the job description ☐ Injured worker ☐ Employer ☐ MCO/BWC
- Does the injured worker have any physical or health restrictions **related to the allowed conditions in the claim** on the date of this exam? ☐ Yes ☐ No
  - **If yes,** are the restrictions: ☐ Permanent? ☐ Temporary?
  - **If no,** check the box to indicate the injured worker is released to return to full duty as of the date of this exam. ☐ ***Proceed to Section 6.***
- If there are restrictions, can the injured worker return to their full duty job held on the date of injury as of the date of this exam? ☐ Yes ☐ No
  - **If yes,** ***Proceed to Section 6.***
  - **If no,** provide date restrictions began ____/____/____ and estimated full duty return-to-work date ____/____/____. ***Proceed to Section 3.***

3 Disability information ☐ Reporting changes from last evaluation ☐ No changes

Complete the chart below for all **work-related allowed conditions being treated**.

Narrative description of the **work-related allowed condition**	Site/Location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

List all other conditions that **impact treatment** of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

Injured worker name	Claim number	Date of injury

4 Abilities, clinical findings, and recovery progression ☐ Reporting changes from last evaluation ☐ No changes

- Is the Injured worker taking prescribed medication for the allowed conditions that may be a safety hazard? ☐ Yes ☐ No
- Dominant hand: ☐ Right ☐ Left
- Circle the injured worker's physical abilities for the activities in the chart below and provide comments as necessary.

Frequency scale	Strength level (lbs.)	Body side indicator
N = Never **S** = Seldom 0-1 hour **O** = Occasional 1-3 hours **F** = Frequent 3-6 hours **C** = Constant 6-8 hours	**S** = Sedentary 0-10 **L**= Light 0-20 **M** = Medium 0-50 **H** = Heavy 0-100 **VH** = Very heavy >100	**L** = Left **R** = Right **B** = Both *Indicate **limitations ONLY**

Activity	Frequency	Activity	Strength	Frequency	Activity	Side
Sit	N S O F C	Floor lift (0-17")	S L M H VH	N S O F C	Front/Lateral reach	L R B
Stand/Walk	N S O F C	Knee lift (18-29")	S L M H VH	N S O F C	Overhead reach	L R B
Climb stairs	N S O F C	Waist lift (30-36")	S L M H VH	N S O F C	Wrist flex/extension	L R B
Squat/Kneel	N S O F C	Chest lift (37-60")	S L M H VH	N S O F C	Grasp	L R B
Crawl	N S O F C	Overhead lift (>60")	S L M H VH	N S O F C	Finger manipulation	L R B
Twist	N S O F C	Push/Pull	S L M H VH	N S O F C	Keyboarding	L R B
Bend/Stoop	N S O F C	Carry	S L M H VH	N S O F C	Operate foot controls	L R B

- Injured worker can work _____hours per day and _____ hours per week.
- Are there any functional restrictions based only on the allowed psychological conditions? ☐ Yes ☐ No
  - If yes, describe any functional restrictions in comments below and reference the MEDCO-16 as needed.
- Provide your clinical and objective findings supporting your medical opinion. List barriers to return to work, reason(s) for delayed recovery, and proposed treatment plan (e.g., modalities, therapies, surgery), including estimated duration of each treatment or indicate if all or part of this information is in office notes (include date(s) of notes).

Comments:

Health and Behavioral Assessment: (HBA evaluates cognitive, emotional, social, and behavioral barriers that might impact physical health problems and treatments which are associated with the allowed physical injury in the claim.)

- Is the injured worker's recovery not progressing, or progressing slower than expected? ☐ Yes ☐ No
- Do cognitive, emotional, social, or behavioral barriers exist that may be interfering with expected healing? ☐ Yes ☐ No

Vocational rehabilitation is a voluntary program for an eligible injured worker who needs assistance to remain at work or return to work. Is the injured worker currently able to participate in a vocational rehabilitation program? ☐ Yes ☐ No

5 Maximum medical improvement (MMI) status ☐ Reporting changes from last evaluation ☐ No changes

MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? ☐ Yes ☐ No

- **If yes**, give MMI date: ____/____/____. ***Note:*** *An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. So, periodic medical treatment may still be requested and, if approved, provided.*

6 Treating physician's signature – mandatory (See exceptions at the top of the form.)

I certify the information on this form is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may be punished, under appropriate criminal provisions, by a fine or imprisonment or both.

Treating physician's name (Print legibly.)		Address, city, state, nine-digit ZIP code	
Treating physician's signature			
BWC provider (PEACH) number	Date	Telephone number	Fax number

WOOD COUNTY, OHIO
Accident/Injury Follow-up & Corrective Action Report

The purpose of this Follow-up & Corrective Action Report is to provide a tool for department supervisors and accident investigators to find underlying causes of an injury, illness, or "near miss" and to document the corrective actions taken. Departments are strongly encouraged to use this form as a method of reducing hazards in their areas and identify system improvements. Employees should understand that accident investigations are not intended to assign blame. See attached **Accident/Injury Investigation Report** for details of the incident.

Employee Name: _____ **Date of injury:** _____

Department: _____ **Classification:** _____

Has the employee been trained on policies/procedures regarding this incident? **Yes** ☐ **No** ☐ **NA** ☐

At the time of the accident/injury, was the employee performing his/her duties in accordance with county policies & procedures? **Yes** ☐ **No** ☐ **NA** ☐

If no, which county policy/procedure was violated? _____

_____

Are additional policy/procedures needed? **Yes** ☐ **No** ☐ **NA** ☐

At the time of the accident/injury, was the employee wearing appropriate personal protective equipment? **Yes** ☐ **No** ☐ **NA** ☐

If yes, what personal protective equipment was used? _____

_____

Was the employee counseled by his/her supervisor regarding their actions? **Yes** ☐ **No** ☐ **NA** ☐

What are your recommendations to prevent similar accidents/injuries? _____

_____

Risk Coordinator's recommendations to prevent similar accidents/injuries: _____

_____

_____

Describe the corrective or preventative action taken to prevent the same accident/injury from occurring in the future.

_____

_____

_____

Corrective action performed by: _____ **on** _____
name date

_____ **on** _____
name date

_____ _____
Supervisor's Signature Department Head Signature

Please return completed form to : Assistant HR Manager
Wood County Commissioners' Office
One Courthouse Square
Bowling Green, OH 43402

by: _____
date