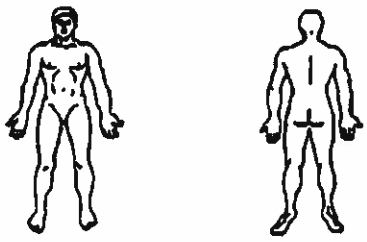
TO BE COMPLETED BY THE INJURED EMPLOYEE:

Employee Name (First, Middle, Last)		Social Security Number		Sex ☐M ☐F	Employee Home Telephone No.
Employee Street Address	City		State	Zip Code	Occupation
Birthdate	Date of Hire	Name of School:			
Date Injury Occurred:		Time of Injury:	Date Notified Employer:		
Indicate name of individual in which you reported the injury:					
In your own words, explain in detail what you were doing immediately before the accident, and how the accident happened:					
Witnesses to Incident:					
Did you or will you seek medical treatment?		Yes	No		
Physician's Name: Physician's Address: Physician's Phone #:					
Indicate on diagram below location of injury and describe symptoms: 					

Employer Section:
Fax or send in report to Gaye Tonar (414-766-5029) within 24 Hours:

Please check one: Employee has not missed time from work: ☐
Employee is off work: ☐

If employee is off work, please indicate reason: Authorized off work ☐
Work restrictions: ☐

Please be sure to attach a copy of the physician's return to work report if available:

South Milwaukee School District
Gaye Tonar
Phone: 414-766-5025
Fax: 414-766-5029

Supervisor or HR Representative:_____ Phone No. _____

ACCIDENT/ILLNESS/INCIDENT INVESTIGATION REPORT:

Part 1: Supervisor completes: To be filled out by supervisor. Employee required to report accidents/incidents to their supervisor immediately at the time it occurs.

Name of Injured Person				Circle One:	
			Employee	Visitor	Volunteer
Date of Report:	Name/Position of person preparing report:				
Supervisor Telephone No.					
Date of Injury:	Time:	am	pm	Left work Yes	No
Address of Accident:					
What was employee doing when injured? Be specific. If using equipment, please name them.					
How did the accident occur?					
How long has the employee been doing job?	Days	Months	Years		
What safety equipment is required on the job for the work being performed?					
Was the employee using all required safety equipment?		Yes	No		
If no, which specific personal protective equipment was not used & why?					
Does an unsafe condition exist that contributed to the cause?		Yes	No		
If yes, what is the condition?					
How could the accident been prevented? Be specific.					
Corrective Action Taken by Supervisor:		Yes	No	Date:	
Reinstruction of person(s) involved					
Equipment repair/replacement					
Improved personal protection equipment					
Reduced congestion					
Improved design/construction					
Discipline of person(s) involved					
Other					
In detail, explain action taken to prevent recurrence:					

WORKERS' COMPENSATION BILLING INFORMATION

EMPLOYER: School District of South Milwaukee
POLICY # : WC-9827701

DIRECT BILL TO:
HASTINGS MUTUAL INSURANCE COMPANY
404 EAST WOODLAWN AVENUE
HASTINGS MI 49058

If you have any questions or concerns, please contact:

Kristina Marada, Senior WC Claim Representative
1-269-948-1835

**Providing this information does not pre-certify or authorize payment. Payment is determined upon receipt of bill and corresponding record per WI WC Statute 102.42

WORK STATUS RECORD

TO: School District of South Milwaukee
901 15th Avenue, South Milwaukee, WI 53172

FROM: Employee Name _____

District Assignment _____

Exam Date _____

Diagnosis _____

_____ S/he may return to work with no limitations on _____ (date)

_____ S/he may return to work with the limitations listed below on _____ (date)

_____ S/he is totally incapacitated until _____ (date)

WORK LIMITATIONS

☐ 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 the category when it requires walking and/or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling or arm and/or leg controls.

☐ Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ Light Heavy Work. Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ Heavy Work. 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 ___S ___W ☐ 4-6 Hours ___S ___W
   ☐ 1-4 Hours ___S ___W ☐ 6-8 Hours ___S ___W

   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:
   ☐ Simple Grasping ☐ Pushing & Pulling
   ☐ Fine Manipulation

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

4. Patient may:

	Not At All	Occasionally	Frequently
a. Bend	☐	☐	☐
b. Twist	☐	☐	☐
c. Squat	☐	☐	☐
d. Climb	☐	☐	☐
e. Reach	☐	☐	☐

OTHER INSTRUCTIONS/LIMITATIONS INCLUDING PERTINENT PRESCRIBED MEDICATIONS _____

_____

THESE LIMITATIONS ARE IN EFFECT UNTIL _____

Provider's Signature_____ (Phone No.)_____ Date_____

Authorization to Release Information

I hereby authorize the release of any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer or his representative.

_____ _____
Patient Signature Date

This form must be completed by the employee's physician for any absence of five or more consecutive days. The original will be placed in the personnel file of the employee and a copy sent to the immediate supervisor.