Claims Reporting

Policy and Procedures

Ohio

Fax or email all completed forms **WITHIN 4 HOURS** of notification of an injury to:

239-415-1114

Or

claim@continuumhr.com

March 2018

OSHA –REPORTING REQUIREMENTS

OSHA requires the reporting of severe work-related injuries and illnesses that all covered employers must adhere. All fatalities must be reported within 8 hours and all inpatient hospitalizations, amputations and loss of an eye within 24 hours to OSHA.

How to report fatalities, severe work-related injuries, and illnesses to OSHA?

You can report to OSHA by:

- Calling OSHA's free and confidential number at 1-800-321-OSHA (6742)
- Calling your closest OSHA Area Office during normal business hours
- Using the new OSHA online form found at: https://www.osha.gov/pls/ser/serform.html

Information Required When Filing a Report

- Establishment name
- Location of the incident
- Time of the incident
- Type of reportable event
- Number of employees injured / deceased
- Names of injured / deceased
- Your contact person and phone number
- Description of incident

Only fatalities occurring within 30 days of the work-related incident must be reported to OSHA. Further, for an inpatient hospitalization, amputation or loss of an eye, these incidents must be reported to OSHA only if they occur within 24 hours of the work-related incident.

Because of the time restraints, **YOU**, the on-site employer should notify OSHA of all reportable events using one of the methods described above. If however, you notify CHR in time and with **ALL** of the required information, we would be happy to assist you by notifying OSHA on your behalf. When calling CHR for assistance in this matter, please be clear in stating that you wish CHR to contact OSHA to report the accident.

Should you have any questions, please feel free to contact the office @239-415-1110 or claim@ContinuumHR.com.

Post Accident Drug Testing

Post accident drug testing is a requirement of your insurance carrier. **In ALL CASES where an employee receives initial medical treatment for a workplace accident, a post accident drug test is REQUIRED.** Drug testing should be preformed the same day of treatment or prior to reporting to work the following day. In almost all cases, a drug test is required within **4 hours, but no later than** 24 hours of the initial incident or of the employee reporting the incident.

We have made this process easier for you by establishing accounts at Labcorp and Quest Diagnostics. By taking the applicable Chain of Custody (COC) form to the location, the employee can be tested and returned to work as quickly as possible and at no cost to you or the employee.

In addition, some Walk-In Clinics perform post accident testing at their facility. If possible, check with the facility prior to sending the employee and see if they use either Labcorp or Quest for testing. If they do, when the employee goes for initial treatment, make sure they bring the appropriate COC. That way, the employee can receive the initial treatment and submit the drug test in the same visit.

It is of the utmost importance that the employee be drug tested within 4 hours, but no later than 24 hours.

While we ask when possible to use a Labcorp or Quest for post accident testing, as long as an accredited lab conducts the test, it will meet your obligation to the carrier.

If your clinic does not use Labcorp or Quest, you can find your nearest lab locations by using the links below. Pay special attention to the times drug testing is offered at each location as it may differ from lab to lab.

LabCorp

https://www.labcorp.com/wps/portal/findalab

Quest

https://secure.questdiagnostics.com/hcp/psc/jsp/SearchLocation.do?newSearch=FindLocation

If you have not received your Chain Of Custody forms or need more, please call our office at 239-415-1110 and we will order more for you.

Please note; the COC's you receive are **ONLY** to be used for post accident testing. All other types of drug tests (pre-hire, random, etc.) are coordinated using the Global HR online system. Please contact our HR Department for further information regarding that process.

Claims Reporting Forms and Procedures

All forms and medical paperwork are to be faxed or emailed to the Claims Center at 239-415-1114 or claim@continuumhr.com

First Report of Injury (FROI)	Complete this form IMMEDIATELY. Do not wait until other forms are completed. Submit to the Continuum HR Claims Center via email or fax within 4 hours of the accident. A sample form has been included as a reference. If an employee requires medical treatment, YOU are required to contact the clinic and arrange the first visit.
AR-1 Employee Injury/Illness Accident Report	Form needs to be completed by the injured worker ASAP following an accident and basic first aid or medical treatment.
AR-2 Supervisor's Accident Investigation Report	Form needs to be completed every time an employee is involved in a work related injury or accident. This form is also to be used for "Report Only" incidents that do not require medical attention. Form should be completed and submitted with the FROI within 4 hours of the accident. This form will assist the supervisor with conducting a thorough investigation
AR-3 Witness Statement Form	Form needs to be completed whenever there is a witness to an accident. Have all witnesses complete this form immediately following the incident, while facts are clear. Once completed, the form should be signed and returned to the Claims Center via email or fax.
Chain of Custody Drug Test Form	Post Accident drug tests are mandatory and must be performed within 24 hours of the incident. Send or escort the employee to the nearest Labcorp facility with the Labcorp Chain of Custody form. Labcorp locations can be found at https://www.labcorp.com/wps/portal/findalab CHR can schedule this appointment for you. Please call 239-415-1110 for assistance.
AR-4 Consent for Release of Medical Information	Form needs to be completed and sent to CHR if/when the employee seeks medical treatment. This completed form proves our ability (CHR / the carrier) to request and receive medical documents relating to the claim directly from the treating facility.
AR-5 Medical Authorization for Initial Treatment	Form should be sent with the injured employee to the medical provider. Fill in the employee's name and Social Security Number before employee seeks treatment.
AR-6 Refusal of Medical Treatment	If an employee reports an incident but refuses medical treatment, have them complete this form immediately. This is not a waiver for all medical treatment. The employee may choose at a later date to seek medical treatment if necessary, however, they MUST follow the state mandated guidelines for Workers Compensation injuries. They cannot go to their personal physician or an ER without prior authorization from the Claims Center. A post accident drug screen may/may not be required when an employee signs this form. Please call CHR for guidance.
Medical Treatment and Paperwork	After any and all medical treatment(s), employees are required to supply the employer with all paperwork provided by the treating physician(s). This paperwork must be faxed immediately to the claims center. The injured employee must keep to all appointments... even if they are feeling better.

Workers Compensation FAQ

Should I send my injured employee to the Emergency Room? Only use ER's for sever/traumatic injury cases, if it is after normal business hours and clinics are closed, OR, if a walk in clinic is not located within a reasonable distance of the employee. Treatment is typically slower in an ER and can cost as much as 5 times more than a clinic for most common workplace injuries.

Should someone go to the clinic with my injured employee the first time? If at all possible you should send a company representative to the clinic with the employee. This shows the employee that you care and ensures that you are aware of any developments or complications with the treatment.

When an employee is injured, should I call the clinic? YES! Contact the nearest clinic and let them know you have an employee on the way, the nature of the injury, and that it is a work comp claim. This is a requirement in some states and is always a good practice. Ensure that the clinic has the "Medical Authorization For Initial Treatment" (AR-5) form.

Why do I have to forward the medical paperwork? Doesn't it come to your and the carrier anyway? Eventually the paperwork may find its way to us and the carrier, however, it may be days or weeks after the treatment. By not forwarding your copies of the paperwork, you could possibly delay necessary treatments, specialist referrals, diagnostics, and increase the overall cost of the claim.

What is "Light Duty"? Light duty refers to tasks the employee has been medically approved to perform while they heal from their injury. Often times the treating physician does not allow the injured employee to perform his/her regular duties based on the physical demands of their original position. The doctor then states on a form what physical activities are allowed during the employees' recovery. The restriction may change after additional medical treatments so always refer to the most recent medical paperwork returned with the employee.

If I have an employee that is taken out of work by the treating doctor, what should I do. Notify us immediately and forward all medical paperwork. Sometimes doctors will make a determination without all the facts about the employees' work responsibilities. We will work with you, the carrier, and the medical provider to ensure that the employee returns to work as quickly as possible.

The employee went to the doctor. They claim to be fine but didn't bring back any paperwork. What should I do? If the employee receives treatment from a medical facility and he/she returns to work "full-duty" with no restrictions, a release from the treating physician must be obtained before the employee may begin work. Call the clinic and have them email/fax the paperwork or send the employee back to obtain the release. You cannot allow them to work without a written release from the treating facility.

Can the employee go anywhere they want for treatment, like to their personal doctor? Absolutely NOT. The employee must go to an approved facility and all visits after the initial care MUST be authorized by the carrier.

How many witnesses need to fill out the Witness Statement Form? If possible, have ALL of the witnesses fill out the form. Often times you will get different accounts that can help in the investigation. Also, should the employee get a lawyer, witness statements help in the defense of the lawsuit.

How do I report a claim that happens after normal business hours? You can call the CHR corporate headquarters like you would call during regular business hours and leave a message. You can send an email or fax. If you need to speak with someone immediately, you may contact Phil Herron on his cell at 678-988-8544. If he does not answer please leave a message and he will get back to you ASAP. The office phone number is 239-415-1110 and the fax number is 239-592-9800. At any time, to email information about a claim please send it to claim@continuumhr.com.

If an employee is involved in auto accident while working, do I need to report it to workers' compensation? If so why? If an employee is injured while performing a job function for the company (even if that function involves driving or riding in a vehicle), it is a workers' compensation claim. The work comp carrier can then try to recoup some of the costs of the claim from the responsible parties auto carrier.

What information is helpful during an investigation of an injury? Pictures, documentation, and witness statements. Take pictures of the equipment and area the employee was working in when the injury happened? Use an item to show scale if possible. Have a person stand in the picture to point out the specific area, part, or location where or how the injury occurred. Document everything; claims forms, name and type of equipment involved (model and SN if applicable), and witness statements.

When an employee has filed a claim and has returned to work on light duty, can they come and go as they please? No. The light duty restrictions will detail if a reduction of hours is necessary for the proper healing of the injury. Other than for medical treatments and/or evaluations, the employee should be expected to maintain a normal work schedule.

Can I fire an employee that has filed a claim? NO! There are very few circumstances that allow for terminating an injured employee without severe penalties to you and your business. In addition, you/we loose complete control of making sure the injured employee follows the medical orders, goes to appointments and treatments, and inevitably the cost of the claim soars. CALL US and we will discuss the situation and assist you with getting the immediate problem corrected.

Can I fire an employee after their claim has been closed? It is against the law to terminate an employee for being injured at work whether the claim is open or closed. However, you can terminate the employee for cause for misconduct or performance reasons with proper written documentation showing a disciplinary process has been followed. CALL US FIRST to review the circumstances and to receive guidance.

If an employee tells me they had an accident on the job, but they don't want to go to the doctor, do we report this? YES! The employee must fill out the refusal form (AR-6) and it must be sent to us immediately. There are many times where an employee initially refuses treatment and then later decides to go. Late reporting causes a number of problems including having to remember forgotten details and possible fines from the state.

Why must the employee take a drug test immediately after being injured? The carrier requires that a drug test be performed. Inn addition, some states require the test to be performed within hours of the incident. To be accepted as part of the claims process, the test has to be timely in relation to the accident. Also, should an employee test positive for drugs or alcohol, by law the compensation benefits can be reduced or the claim can be denied outright. This has the potential of saving YOU money.

Can we reduce the wages of an injured employee working light duty work? The employee should be paid as close to their normal wages as possible based on the restrictions and work that is available. An employee returning to work but unable to perform their normal duties can be assigned other duties that meet the light duty restrictions. The employee only has to be paid what the interim job is worth, but it SHOULD be at least 80% of their current pay. If the employee meets the requirements, a percentage of the difference between the two wages will be made up by the workers' compensation carrier. If you choose to pay a lower than current wage, please call CHR and let us know so that we file the correct paperwork to ensure that the employee is paid what they are owed.

Must we work an injured employee their normal work hours/shift? It is always better for the overall cost of the claim to have the employee work a normal schedule if the restrictions allow it. If you do not have enough light duty work to support a regular shift, you do not have to create work to keep the employee busy. If you are having difficulty providing hours to an injured employee, please contact CHR and we discuss the situation with you.

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

By signing this form, I:

- **Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;**
- **Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;**
- **Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;**
- **Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

Injured worker and injury/disease/death info.

Last name, first name, middle initial | Social Security number | Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Date of birth

Home mailing address | Sex ☐ Male ☐ Female | Number of dependents

City | State | 9-digit ZIP code | Country if different from USA | Department name

Wage rate $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____ | What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat | Regular work hours From _____ To _____

Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain. | Occupation or job title

Employer name

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

Date of injury/disease | Time of injury _____ ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work _____ ☐ a.m. ☐ p.m. | Date last worked | Date returned to work

Date hired | State where hired | Date employer notified | State where supervised

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.) | Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature | Date | E-mail address | Telephone number | Work number ( )

Treatment info.

Health-care provider name | Telephone number ( ) | Fax number ( ) | Initial treatment date

Street address | City | State | 9-digit ZIP code

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No | Is the injury causally related to the industrial incident? ☐ Yes ☐ No

E code | 11-digit BWC provider number | Date

Health-care provider signature

Employer info.

Employer policy number | Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm

Telephone number ( ) | Fax number ( ) | E-mail address | Federal ID number | Manual number

Was employee treated in an emergency room? ☐ Yes ☐ No | Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification -** The employer certifies that the facts in this application are correct and valid.

☐ **Rejection -** The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only

☐ **Clarification -** The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title | Date | OSHA case number

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

This form can be completed and submitted online at **www.bwc.ohio.gov**

Report your injury by completing all three sections of this form

1. Complete as much of all three sections of this form as possible to reduce the time necessary in determining the claim. If this form is completed by the injured worker at the first visit to a medical provider, the injured worker may give the FROI to the provider to complete the treatment information section.The provider can then submit the FROI to the MCO.
2. Deliver, mail or fax the completed document to your employer or your employer's managed care organization (MCO).
3. If you do not know your employer's MCO, contact BWC at **1-800-644-6292** and follow the prompts, or use the MCO on BWC's Web site at **www.bwc.ohio.gov.**
4. If you are unable to determine your MCO, mail or fax this form to the BWC customer service office closest to your home. For information on your local customer service office, please visit **www.bwc.ohio.gov.**, or call **1-800-644-6292**.

Injured workers employed by a self-insuring employer

- Complete this form and give to your employer.
- Your employer should be able to tell you if he or she is a self-insuring employer.
- If your employer is self-insuring and you file this information with BWC, processing delays may occur.

For assistance in completing this form, call your BWC customer service office Monday through Friday, 8 a.m. – 5 p.m.

Cambridge
61501 Southgate Road
Cambridge, OH 43725-9114
Phone: 740-435-4200
Fax: 866-281-9351

Canton
339 E. Maple St., Suite 200
North Canton, OH 44720-2593
Phone: 330-438-0638
Toll free: 800-713-0991
Fax: 866-281-9352

Cleveland
615 Superior Ave. W.
Cleveland, OH 44113-1889
Phone: 216-787-3050
Toll free: 800-821-7075
Fax: 866-336-8345

Columbus
30 W. Spring St.
Columbus, OH 43215-2256
Phone: 614-728-5416
Fax: 866-336-8352

Dayton
3401 Park Center Drive, Suite 100
Dayton, OH 45414-2577
Phone: 937-264-5000
Fax: 866-281-9356

Garfield Heights
4800 E. 131 St., Suite A
Garfield Heights, OH 44105-7132
Phone: 216-584-0100
Toll free: 800-224-6446
Fax: 866-457-0590

Cincinnati–Governor's Hill
8650 Governor's Hill Drive
Cincinnati, OH 45249-1369
Phone: 513-583-4400
Fax: 866-281-9357

Lima
2025 E. Fourth St.
Lima, OH 45804-4101
Phone: 419-227-3127
Toll free: 888-419-3127
Fax: 866-336-8346

Mansfield
240 Tappan Drive, N., Suite A
Ontario, OH 44906-1366
Phone: 419-747-4090
Fax: 866-336-8350

Portsmouth
1005 Fourth St.
Portsmouth, OH 45662-4315
Phone: 740-353-2187
Fax: 866-336-8353

Toledo
P.O. Box 794
1 Government Center, Suite 1136
Toledo, OH 43697-0794
Phone: 419-245-2700
Fax: 866-457-0594

Youngstown
242 Federal Plaza, W., Suite 200
Youngstown, OH 44503-1206
Phone: 330-797-5500
Toll free: 800-551-6446
Fax: 866-457-0596

Completion instructions (continued)

Injured worker and injury/disease/death info.

Last name, first name, middle initial | Social Security number | Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Date of birth

Home mailing address (1) | Sex ☐ Male ☐ Female | Number of dependents

City | State | 9-digit ZIP code | Country if different from USA | Department name (2)

Wage rate $_____ Per: (3) ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other_____ | What days of the week do you usually work? (4) ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat | Regular work hours From ____ To ____ (4)

Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ YES ☐ NO If yes, please explain. (5) | Occupation or job title (6)

Employer name (7)

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was place of accident or exposure on employer's premises? ☐ Yes ☐ No
If no, give accident location, street address, city, state and ZIP code.

Date of injury/disease (8) | Time of injury _____ ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work _____ ☐ a.m. ☐ p.m. | Date last worked (9) | Date returned to work (10)

Date hired | State where hired (11) | Date employer notified (12) | State where supervised (13)

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death) (14) | Type of injury/disease and part(s) of body affected (for example: sprain of lower left back, etc.) (15)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature (16) | Date | E-mail address | Telephone number ( ) | Work number ( )

Injured worker and injury/disease/death info.

(1) Home address: Enter the home address where the injured worker lives. Include the apartment number, if applicable.
- If the post office does not deliver mail to the home address, list the mailing address instead of the home address.

(2) Department name: Enter the injured worker's department or area name where he/she normally reports for work.

(3) Wage rate: Enter the injured worker's rate of pay, and then select how often it is received. (If the pay rate being reported is not hourly, report the gross amount.)
- If eight or more days of work will be missed, BWC needs wage information for the 52 weeks prior to the date of injury. Submit wage information using employer payroll reports, wage statement (BWC form C-94-A), W-2s, etc.

(4) What days of the week do you usually work? What are your regular work hours: Enter the days and hours the injured worker normally works.
- If the days worked vary from week to week, list the number of hours worked in an average week.

(5) Wages: If you received wages during disability, please explain.

(6) Occupation or job title: Enter the injured worker's type of occupation or actual job title at the time of injury, occupational disease or death.

(7) Employer name: Enter the name of the injured worker's employer at the time of the injury, occupational disease or death.

(8) Date of injury/disease: Enter the date injured worker was injured. OR
If the injured worker contracted an occupational disease, determine which of the following happened most recently:
- The occupational disease was diagnosed by a medical provider;
- The first medical treatment;
- The injured worker first quit work, due to the occupational disease.

Enter this as the date of occupational disease.

(9) Date last worked: Enter the last day worked as a result of this injury, occupational disease or death.

(10) Date returned to work: Enter the date the injured worker returned to work after the injury or occupational disease.

(11) State where hired: Enter the state where the injured worker was hired by the employer listed on this application.

(12) Date employer notified: Enter the date the employer was notified of the injury, occupational disease or death.

(13) State where supervised: Enter the state where the injured worker was supervised by the employer listed on this application.

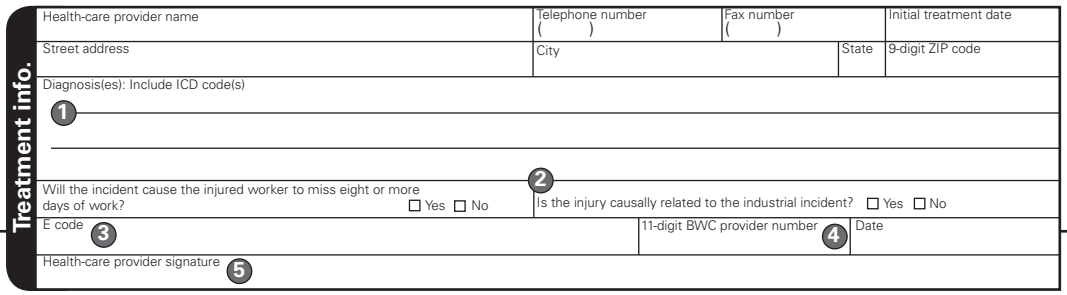
(14) Description of accident: Describe in detail the events that caused the injury, occupational disease or death. Attach additional sheets, if necessary.

(15) Type of injury/disease and part of body affected: Describe the nature of the injury, occupational disease or death.
Indicate the part(s) of body injured, affected or that caused the death.
Examples:
- Laceration of first toe, left foot;
- Sprain of lower right back; etc.

(16) Injured worker signature (injured workers only): Please read the Benefit application/medical release information before signing and dating this form.

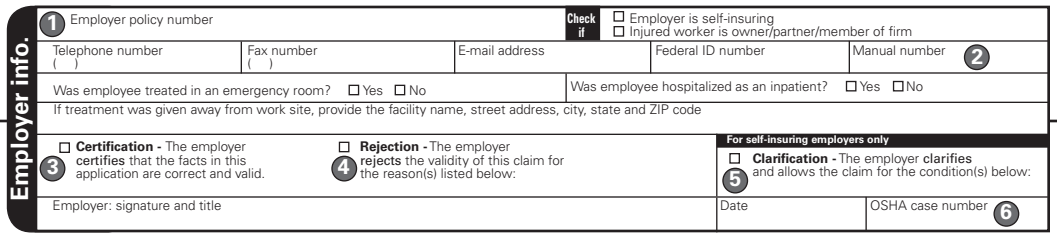
Instructions continued on last page

Completion instructions
(continued)



Treatment info.

1. Indicate the diagnosis and ICD codes for conditions being treated as a result of the injury.
2. Indicate the treating provider's medical opinion that the injury sustained is causally related to the industrial incident, that the injury could result from the method (manner) of the accident, as described by the injured worker. It must be clear that the diagnosis in all probability occurred as a result of the injury.
3. Providing a valid E code will enable us to determine the claim more quickly and efficiently.
4. Enter the physician's or health-care provider's 11-digit BWC-assigned provider number.
5. Signature of the health-care provider completing this form.



Employer info.

1. Enter the employer's BWC-assigned policy number, which is located on the BWC certificate of coverage.
2. Enter the four-digit code that indicates the injured worker's job classification, located on the semiannual payroll report.
   - If you do not know the injured worker's manual number, call **1-800-644-6292** and follow the prompts.
3. If certification is selected and the claim is allowed, it will promptly be paid. Employers certifying a claim waive both the notice of receipt and notice of first order of compensation.
4. If rejection is selected, use the space provided to list the reasons for rejection. Attach additional sheets, if necessary.
5. Self-insuring employers that choose to clarify certification may use the space provided. Attach additional sheet, if necessary.
6. If this is an OSHA-reportable injury, include the case number assigned by the employer.This form meets OSHA 301 requirements and may be used in lieu of the OSHA 301 when reporting recordable injuries and illnesses to the federal government.

Note:
If your employee misses eight or more days of work, BWC will need wage information for the 52 weeks prior to the date of injury. Submit wage information using employer payroll reports, wage statement (BWC form C-94-A), W-2s, etc.

EMPLOYEE'S REPORT OF INJURY AR - 1

All injuries must be reported **IMMEDIATELY** to your supervisor even if treatment is not required

Client:	**Accident Location:**
Employee:	**Social Security:**
Employee Address:	**Phone:**
City, State: **Zip:**	**Job Title:**

Date of Injury:	**Time of Injury** AM / PM
Body Part (s) Injured	**Cause of injury**

Describe What Happened in detail (be specific):

_____

_____

_____

_____

_____

_____

The following people were present and might be a witness:

I probably will need further medical treatment:. ……☐Yes ☐ No

I, employee, the undersigned, certify that the above is a true and correct statement of fact and that I made such statements of my own free will. I understand that any payments to me or anyone else for expenses in connection with my accident and resulting injury is not an admission of liability on the part of **Continuum HR.** I authorize full access to copies of medical records, radiology reports, drug/alcohol screenings, and documents of any kind relating to my past or present injury/illness to **Continuum HR**. I herby agree to release this information and hold all such medical providers harmless for the release of this information as set forth in this authorization.

"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

_____ _____

(Signature of Employee) (Date) **(Printed Name of Supervisor)** (Date)

(**Translator**) _____

Any person who knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self insured program, files a statement or claim containing any false or misleading information is guilty of a felony of the third degree.

DRUG TESTING.--An employer may test an employee or job applicant for any drug ("Drug" means alcohol, including a distilled spirit, wine, a malt beverage, or an intoxicating liquor; an amphetamine; a cannabinoid; cocaine; phencyclidine (PCP); a hallucinogen; methaqualone; an opiate; a barbiturate; a benzodiazepine; a synthetic narcotic; a designer drug; or a metabolite of any of the substances listed in this paragraph. An employer may test an individual for any or all of such drugs, and may deny medical and indemnity benefits for a refusal or positive test.

Fax or email to Claims Center at 239-415-1114 or claim@continuumhr.com

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT AR – 2

Client:	Employee:
Date of Injury:	Time of Accident: AM/PM
Chain of Custody Number/ Drug Test Form #:	Department:
Date the employee reported the accident to you:	

Please Complete All Questions

Has the injured employee requested medical treatment)? ☐Yes ☐No
(**Have employee complete refusal of treatment "Form AR-6" – if applicable**)

Job being performed: _____ Was this his/her regular job? ☐Yes ☐No

Place of Job (parking lot, garage, residential home): _____

Job Site Address (be specific) _____

How many hours was the employee on the job before the accident occurred? _____ Start Time: _____

Last full day worked before injury: _____ County of Injury: _____

Describe the Accident: _____

_____

_____

What did employee do or fail to do that contributed to the accident?_____ _____

_____ _____

What body part was injured? _____ Any Witnesses: ☐Yes ☐No

Were you present at the accident location during the incident?	☐Yes	☐ No
Did you witness the incident?	☐Yes	☐ No
Are there issues or circumstances that make you question the employees' account of the incident or nature/severity of the injury?	☐Yes	☐ No
Was a post-accident drug screen performed?	☐Yes	☐ No
Is light duty available for this injured employee?	☐Yes	☐ No
Do you believe the employee will lose time from work beyond medical treatments?	☐Yes	☐ No
Was the employee cited for the accident?	☐Yes	☐ No
Was employee paid for the rest of the day? If No, when was last hour paid thru? _____	☐Yes	☐ No
Did the employee willfully refuse to use a safety appliance or have prior knowledge and willfully refused to observe a safety standard or rule?	☐Yes	☐ No

Where did the employee go for treatment (Name of clinic/hospital)? _____

Clinic/ Hospital Address and phone #: _____

How were they transported to treatment (car, ambulance)? _____ Work Status: _____

Was the accident a result of ☐ Unsafe Act or ☐ Unsafe Condition? First day of treatment? _____

Supervisor Print Name _____ Signature of Supervisor_____

Direct Phone/Cell Line: _____ Date: _____

Fax or email to Claims Center at 239-415-1114 or claim@continuumhr.com

WITNESS STATEMENT **AR - 3**

Client:	**Accident Location:**
Witness Name:	**Home Phone:**
City, State: **Zip:**	**Job Title:**

Name of Injured Worker:	**Are you related to the injured worker**? ☐ Yes ☐ No
Date of Injury:	**Time of Injury** AM / PM
Body Part (s) Injured	**Cause of injury**

Was the accident a result of: ☐ An Unsafe Act or ☐ An Unsafe Condition?

Was the injured employee wearing any safety equipment (i.e. goggles, gloves, back braces, hearing protection)? ☐ Yes ☐ No

Describe What Happened, in detail, what you saw or know regarding this incident:

_____

_____

_____

_____

_____

List names of any other persons who may have information regarding this incident:_____

_____

_____

_____

Is there any other information that you know that would assist in providing a fair evaluation of this incident?

_____

_____

_____

_____

_____

Fax or email to Claims Center at 239-415-1114 or claim@continuumhr.com

AR - 4

Consent For Release Of Medical Information

I hereby authorize representatives of Continuum HR and / or Continuum HRs' Workers' Compensation Carrier to be permitted to obtain and review copies of all medical records related to my workers' compensation injury. This pertinent information will be discussed with other professionals involved in my medical treatment and any institution that, through the "Workers' Compensation Program" or otherwise is paying all or part of the cost associated with my medical care.

Employee Name	Social Security Number
Injury Date	Telephone Number
Name of Employer	
Signature of Employee	Date
Witness	Date

A PHOTOCOPY OR FACSIMILE COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

Fax or email to Claims Center at 239-415-1114 or claim@continuumhr.com

MEDICAL AUTHORIZATION FOR INITIAL TREATMENT AR - 5

To: Medical Treatment Facility,

Please **verify** the active status of the injured employee being treated by calling us at 239-415-1110. You are authorized to give a **ONE TIME INITIAL** treatment as necessary to our employee. **Please ensure all injured employees are drug tested *or*** told to go to the designated facility.*

***If drug test collection is not performed at this location, please advise the Employee to go to the drug test location listed on the chain of custody form.**

Employee Name	Social Security Number

Authorized by:
Continuum HR
11691 Gateway Blvd Ste 104
Ft. Myers, FL 33913
(239) 415-1110

Send billings to:
Continuum HR
11691 Gateway Blvd Ste 104
Ft. Myers, FL 33913
(239) 415-1110

Please fax or email all treatment records including restrictions to Continuum HR following treatment.

We require all physicians who provide treatment for a reported work related injury submit all relevant documents to the insurer and the employer immediately but no later than three (3) business days after the visit.

Please fax or email all medical paperwork to 239-415-1114, Attention Claims Center or claim@continuumhr.com

If possible, inform us of any follow up treatment and also of any ***missed*** appointment by calling our offices at 239-415-1110.

Please Ensure All Injured Employees are Drug Tested.

Note to **Client/ Employer**: Employee must carry a chain of custody form **AND** this authorization form to the assigned Medical Treatment Facility and/or pharmacy.

REFUSAL OF TREATMENT FORM AR – 6

Client:	**Incident Date:**
Employee:	**Social Security:**
Employee Phone:	**Incident Location:**

I was involved in an incident on the above-mentioned date. I sustained no injuries. I was offered medical attention, but saw no need for medical treatment, because I sustained no injuries in the incident.

If my condition changes in the future, I agree to notify my supervisor and call the CHR Claims Center at 239-415-1110. I realize that medical treatment will be provided and I will receive authorization so that I might obtain medical attention, which, at this time, I have refused.

Please describe the incident in detail:
Please list specific body parts affected (i.e. Right thumb, Upper back, Left ankle, etc.):
The following people may have been a witness to the incident:

Signature Date

Supervisor Signature Date

Fax or email to Claims Center at 239-415-1114 or claim@continuumhr.com

RETURN TO WORK

Purpose

The purpose of a Return To Work program is to enable the employee to work and be productive during the period of the employees' recovery from an injury. This not only allows you to retain experienced staff, but also reduces the cost of the claim and increases employee morale.

CHR has established guidelines to return an injured employee to work following their injury as set forth in our contract. The employee will be placed on "light duty" (modified duty, transitional duty, limited service) as soon as he or she is able to do so prescribed by the treating medical provider. You are required to make light duty work available, as long as the restrictions are within reason, as soon as the employee is released to work by the treating physician. If you feel the restrictions are burdensome or if you have no work available, call us IMMEDIATELY and we will work with you, the doctor, the carrier, and the employee, so that YOU can keep your claims costs low and productivity high.

Lost Time / Return To Work FAQ

How often should I talk to an employee that has been placed out of work by the doctor? You should require the employee to call or visit your establishment a minimum of once per week. If the employee has been to the doctor, require the employee to drop off or send in any medical paperwork they have received immediately. Ask the employee how they are doing, when their next treatment is, and when they expect to return to work. Report any new information to CHR.

What do I need to do when an employee returns to work after missing time from an injury? Verify that the employee has obtained a release from the doctor by either A) reviewing the medical release supplied by the employee from the doctor, or B) calling CHR and have us verify the release. Sometimes an overeager employee will say they have been released and it not be true.

The employee has doctor restrictions and has returned to work. What do I need to do? Sometimes an employee may be released from the doctor to return to work with physical restrictions. The supervisor and the employee must review these restrictions carefully and discuss what work the employee can do within the limitations set by the medical provider. Do not allow the employee to work beyond those restrictions or it may impede the healing process or possibly make the injury worse.

What should I do if an employee has been released to work but doesn't show up for their shift? Try to contact the employee and ask why they are not present. Report the "No-Show" and any findings to CHR. Even if you choose not to discipline the employee, document the absence and have the employee sign it upon their return. It is imperative that you notify and submit the documentation to CHR so that we can properly manage the claim and keep the costs to a minimum.

Will an employee be paid if they miss time due to an injury? Possibly. The first seven (7) days of lost time work is not payable by the workers' compensation system. In addition, if the doctor does not place the employee "off work" and/or if the employee *CHOOSES* to stay home, they will not be compensated. If you wish to pay the employee (by using vacation time, etc.), contact the Claims center at (239) 415-1110 for a discussion of the proper method. Do not just put them on the payroll. If, however, the treating physician places the employee off work for more than 7 days, they will be paid a portion of their average wages.

How are lost time wages calculated? – Depending on individual state statutes, loss wages are calculated based on average wages earned over a set period of time. Usually, and injured employee will receive sixty six and two thirds (66 and 2/3rds) of the calculated average wage.
Example: Florida uses the 13 weeks leading up to the injury date to calculate the average pay.
Example: Georgia uses the previous years' earnings to calculate the average pay.
If there is not enough historical data to support the primary method for calculation, a "similar" employee (in position, duties, and pay) is selected and their time and earnings are used to establish an average wage for the injured employee.

When can my employee expect to receive their benefit check(s) from the carrier? – After the injured employee is eligible to receive benefits, the carrier then begins to process the benefit payment. Payments will be sent directly to the employee on a bi-weekly cycle.

What if my company does not have light duty available? Only in extreme cases are there no possibilities for making light duty available. Call CHR immediately and we will discuss with you the light duty restrictions and ways to get the employee back to work. Return To Work programs have been proven to reduce the costs of claims by 10% to 30%. We have access to several Return To Work options that you may not be aware of.

How do I let an employee know I have light duty available? What should I do to protect our company when we offer an injured employee light duty work? If the employee is present, sit down with them and the supervisor and discuss the light duty. Have the details put on paper and have the employee sign. Some states require that a formal light duty job offer be in writing and have a detailed job description that meets the restrictions. You must specify a date and time the employee is to report and exactly who the employee is to report to. The document must be sent to the employee certified mail, Fed Ex (signature required), or hand delivered to the employee with a receipt signature. The date the employee must report to work must allow for the time it takes to have the letter delivered (usually 5 days). The employee must be made to sign and date the document and return it for your files (copy to CHR). Even if this is not required in your state, it remains an excellent way to protect your business. CHR has developed a document for this purpose and we will be happy to assist you on its completion.