Mankato Area Public Schools

**First Report of Injury Packet – July 2019**

**Your Packet Includes: 1. Supervisor’s Report**

**2. Quick Reference Guide to Reporting Work Injuries**



**As of July 1, 2019 the district has a new**

**Workers’ Compensation Carrier:**

|  |  |  |  |  |  |  |
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| **Quick Reference Guide - Reporting Work Injuries** | | | | | | |
| **When someone’s injured at work……** | | | | |  |  |
| **If it’s an** **emergency, call 911.** | |  |  | |  |  |
| ⏹ Otherwise, the employee and supervisor should call (855) 675-3501 together. (If no supervisor is available, the employee can call alone) Do this as soon as possible after you learn of an injury. | | | | | | |
| ⏹ The registered nurse who answers will ask what happened and recommend what to do next, whether it’s self-care, urgent care or even the emergency room. | | | | | | |
| ⏹ The nurse will report the injury to SFM, your workers’ compensation insurer. You don’t need to fill out a first report of injury. | | | | | | |
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| **Contacts and Next Steps** | | | | | | |
| **When calling the hotline, the following information may be needed for identification purposes:** | | | | | | |
| Employer: **Mankato Area Public Schools** | | | |
| Location Name & Address: **Give your building information** | | | |
| Policy Number: **1 1 7 8 2 5** | | | |
| Your Organization’s Contact – Claims Coordinator:  **Scott Hogen, Director of Facilities** | | | |
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| **After the call…** | | | | | | |
| ⏹ If a doctor’s visit is required, ask the employee to take along  a report of work ability to be completed by the physician. | | | | | | |
| ⏹ Gather additional information about the incident. | | | | | | |
| ⏹ If recovery will require time off work, report this to SFM.  Call 1-800-937-1181 to reach your claims representative. | | | | | | |
| ⏹ Stay in contact with injured employees. Let them know they’re missed, and you’ll have jobs for them when they’re ready to return to work. | | | | | | |
| ⏹ Ask the injured worker to call their claims representative before undergoing diagnostic tests, such as MRIs or ordering medical equipment. | | | | | | |
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| **Contact SFM to report an injury:**  **855-675-3501 sfmic.com** | **General Questions:**  **952-838-4200 or 800-937-1181** | | | | | |

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| **SUPERVISOR’S REPORT OF ACCIDENT** | | | | | | | | | | | | | | | | | | | | | | |
| *(Please read and follow instructions on back)* | | | | | | | | | | | | | | | | | | | | | | |
| Every accident should be investigated and the causes corrected so that more accidents will not occur. Do not overlook the so-called “unimportant” cases, because, except for “chance” they could also have been serious. It is only by thorough investigation that many of the real causes can be determined and corrected. | | | | | | | | | | | | | | | | | | | | | | |
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| NAME OF EMPLOYEE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | SCHOOL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Dept:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
|  | | | | | | | | |  | | | | | | |  | | | | | | |
| DATE OF ACCIDENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | TIME:\_\_\_\_\_\_\_\_\_\_\_\_ | | DID EMPLOYEE LOSE TIME FROM WORK? | | | | | | | | | | | YES 🞎 NO 🞎 | | |
|  | | | | | | | | |  | | | | | | |  | | | | | | |
| HOURS LOST ON DATE OF ACCIDENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | HAS EMPLOYEE RETURNED TO WORK? | | | | | | | | | | | YES 🞎 NO 🞎 | | |
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| JOB TITLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | SERVICE WITH THE COMPANY:\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | YEARS IN PRESENT JOB?:\_\_\_\_\_\_\_ | | | | | | | |
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| **GIVE US YOUR HONEST COMMENTS ON QUESTIONS BELOW. WE ARE NOT TRYING TO BLAME ANYONE.**  **YOUR OPINION MAY HELP US PREVENT ACCIDENT REPETITION.** | | | | | | | | | | | | | | | | | | | | | | |
| ***PLEASE ANSWER THE FOLLOWING:*** | | | | | | | | | | | | | | | | | CHECK “YES” OR “NO | | | | | |
| 1. Was injured person properly instructed in safe and efficient methods?………………………………………. | | | | | | | | | | | | | | | | | YES 🞎 | | | NO 🞎 |
| 2. Did injured person violate any instructions?……………………………………………………………………… | | | | | | | | | | | | | | | | | NO 🞎 | | | YES 🞎 |
| 3. Was necessary protective equipment worn? (if applicable)……………………………………………………. | | | | | | | | | | | | | | | | | YES 🞎 | | | NO 🞎 |
| 4. Did poor housekeeping contribute to injury?……………………………………………………………………… | | | | | | | | | | | | | | | | | NO 🞎 | | | YES 🞎 |
| 5. Did horseplay cause the injury?……………………………………………………………………………………. | | | | | | | | | | | | | | | | | NO 🞎 | | | YES 🞎 |
| 6. Was it caused by something which needed repairs?……………………………………………………………. | | | | | | | | | | | | | | | | | NO 🞎 | | | YES 🞎 |
| 7. Should a guard be provided?………………………………………………………………………………………. | | | | | | | | | | | | | | | | | NO 🞎 | | | YES 🞎 |
| 8. Did any bodily defect contribute to injury?………………………………………………………………………… | | | | | | | | | | | | | | | | | NO 🞎 | | | YES 🞎 |
| 9. Was it caused by an unsafe act?…………………………………………………………………………………... | | | | | | | | | | | | | | | | | NO 🞎 | | | YES 🞎 |
| 10. Did injured report the injury to you, the supervisor, immediately?……………………………………………… | | | | | | | | | | | | | | | | | YES 🞎 | | | NO 🞎 |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **ACCIDENT:** (Describe what injured person was doing at time of accident. What happened, who was involved, nature of injury, part of body affected.) | | | | | | | | | | | | | | | | | | | | | | |
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| **WITNESSES’ NAMES:** | | | |  | | | | | | | | | | | | | | | | | | |
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| **UNSAFE ACTS:** (What did the employee or another person do incorrectly?) | | | | | | | | | |  | | | | | | | | | | | | |
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| **UNSAFE CONDITIONS:** (What unguarded or unsafe condition of machinery, equipment, building or premises was involved?) | | | | | | | | | | | | | | | | | | | | | | |
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| **ACTIONS TAKEN:** (What did you do to correct the conditions which caused this injury?) | | | | | | | | | | | | |  | | | | | | | | | |
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| **REMEDIES:** (What should your organization do to prevent other injuries like this?) | | | | | | | | | | | |  | | | | | | | | | | |
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| **MEDICAL CARE:** Did employee go to doctor or hospital? YES 🞎 NO 🞎 | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **NAME of Doctor or Hospital:** | | | | | |  | | | | | | | | Date of initial visit: | | | | |  | | | |
| ADDRESS: | |  | | | | | | | | | | | | Phone Number: | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS’ COMPENSATION? YES🞎 NO🞎 | | | | | | | | | | | | | | | | | | | | | | |
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| REASONS WHY: | | |  | | | | | | | | | | | | | | | | | | | |
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| REPORT SUBMITTED BY: | | | | |  | | | | | | DATE: | | |  | | | | | | | | |
| **Return this form to the Director of Facilities at the Central Business Office.** | | | | | | | | | | | | | | | | | | | | | | |

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| **COMPLETION INSTRUCTIONS FOR SUPERVISORS’ REPORT OF ACCIDENT (SRA)** | | | |
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| The primary purpose of the SRA is to investigate the accident. It is also used to report the accident to the Central Office where the First Report of Injury is then completed by administrative personnel. The SRA should be filled out as soon as possible after the accident. | | | |
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| If the SRA is incomplete or delayed, corrective action may also be delayed. A delay in taking corrective action will probably result in the occurrence of a similar accident. | | | |
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| The initial information asked for at the top of the SRA concerning the injured person’s name, age, job history, and loss of time from work is self-explanatory, but very necessary for eventual completion of the First Report of Injury. | | | |
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| The following is a line-by-line set of instructions for completing of the SRA by the Supervisor of the injured employee. Concrete examples of important parts of the form are given for your use. This report should **not** be completed by the injured person. | | | |
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| QUESTIONS | | | |
| 1. Was proper instruction given to the employee on how to do the job safely? Supervisors should instruct their employees on how to do the job efficiently and safely. | | | |
|  | | | |
| 2. Referred to in question #1. | | | |
|  | | | |
| 3. The supervisor should have told the employee what personal protective equipment is necessary to do the job. Did the employee wear the personal protective equipment when this job was being done? | | | |
|  | | | |
| 4. Was the work area clean and well organized? (i.e., scraps on the floor, blocked aisles, wet floor, spilled food, etc.) | | | |
|  | | | |
| 5. Was there inadequate supervision? Did horseplay or practical jokes contribute to the accident? | | | |
|  | | | |
| 6. Was the injured person using equipment that was unsafe and in need of repair? (i.e., broken ladder, bad electric cord on drill, etc.) | | | |
|  | | | |
| 7. Would a guard prevent another accident from happening? i.e., guard around the belts and pulleys, railing properly in place, guard, on saw, etc. | | | |
|  | | | |
| 8. Did this person have any bodily defects which might have help cause the accident? (i.e., poor vision, previous back injury, etc.) | | | |
|  | | | |
| 9. Most injuries are caused by unsafe acts. An Unsafe Act is something that the injured person or another person did, that he or she should not have done, which let to the accident. Below is a list of the most common unsafe acts and contributing factors: | | | |
| a. Operating without authority | g. Failure to use personal protective equipment | | l. Adjusting, clearing jams, cleaning machinery in motion |
| b. Failure to warn or secure | h. Failure to use equipment provided | | m. Distracting, teasing |
| c. Operating at unsafe speed | (except personal protective equipment) | | n. Poor housekeeping practices |
| d. Making safety devices inoperative | i. Unsafe loading, placing and mixing | | o. Disregard of instructions |
| e. Using equipment, tools, materials or vehicles unsafely | j. Unsafe lifting, carrying (including insecure grip) | | p. Lack of knowledge or skill |
| f. Using defective equipment, materials, tools or vehicles | k. Taking an unsafe position | | q. Act of other than injured r. Other… |
|  | | | |
| 10. The accident should have been reported immediately to the supervisor, was it? | | | |
|  | | | |
| **ACCIDENT:** | | | |
| 1. Describe what the injured was doing at the time of the accident. | | | |
| 2. What happened? | | | |
| 3. Who was involved? | | | |
| 4. What injuries resulted? | | | |
| (Example: John was drilling a hole in the ceiling and chips of plaster fell into his eye. (This answers questions 1 & 2.) John was wearing prescription safety glasses but got chips of plaster in his eye resulting in scratches to his eye (This answers questions 3 & 4). Note the names of witnesses, if any. | | | |
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| **UNSAFE ACT:** Refer to question 9 above and examples of Unsafe Acts. Example: John was not wearing proper personal protective equipment. | | | |
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| **UNSAFE CONDITIONS:** | | | |
| a. Defective tools, equipment, substances | d. Improper illumination | g. Poor housekeeping | |
| b. Unsafe design or construction | e. Improper ventilation | h. Congested area | |
| c. Hazardous arrangement | f. Improper dress | i. Other | |
|  | | | |
| **REMEDY:** Example – standard safety policy should be adopted that requires use of personal protective equipment. This policy should be strictly enforced by the supervisors. | | | |
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| **MEDICAL CARE:** Include all medical information that is known at this time. Do not delay the completion of this form for more complete information. | | | |

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| **WORK ABILITY /**  **RETURN-TO-WORK** | | | | | | | |  | | | **Send itemized medical billings and records to:**  **SFM Companies**, PO Box 9416, Mpls, MN 55440  Fax: (952) 838-2000 Phone: (800) 937-1181 | | | | | | | |
|  | | | | | | | Send this completed form with the employee | | | | | | | | | |  | |
| **EMPLOYEE** | | | | | | | | | | | | | HEIGHT | | | WEIGHT | | DATE OF BIRTH |
| **EMPLOYER**  **Mankato Area Public Schools** | | | | | | | | | | | | |  |  | | **DATE OF INJURY/ILLNESS** | | |
|  | | | | | | | | | | | | |  | | |  | |  |
| **DIAGNOSIS** | | | | | | | | | | | | |  | | |  | | ICD-10 CODE |
| History, mechanism of injury, and findings:  Work related injury/illness? □ No □ Yes □ To be determined  Any pre-existing conditions affecting this injury/illness? □ No □ Yes, description:  Permanent partial disability? □ No □ Yes, \_\_\_\_\_\_\_\_\_\_\_%  Maximum Medical Improvement reached? □ No □ Yes, date reached \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| ***RETURN TO WORK*** | | | | | | | | | | | | | | | | | | |
| □ Return to work ***with no limitations*** on mo:\_\_\_\_\_\_\_\_/ day:\_\_\_\_\_\_\_/ year:\_\_\_\_\_\_  □ Return to work ***with limitations*** on mo:\_\_\_\_\_\_\_/ day:\_\_\_\_\_\_\_/ year:\_\_\_\_\_\_\_ through mo:\_\_\_\_\_\_\_/ day:\_\_\_\_\_\_\_/ year:\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has light-duty work available. Please call \_\_\_\_\_\_\_\_\_\_\_\_\_ at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_if you plan to take this employee off work.  □ Unable to work from mo:\_\_\_\_\_\_\_\_/ day:\_\_\_\_\_\_\_/ year:\_\_\_\_\_\_ through mo:\_\_\_\_\_\_\_\_/ day:\_\_\_\_\_\_\_/ year:\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| ***EMPLOYEE’S CAPABILITIES*** | | | | | | | | | | | | | | | | | | |
| Body Part Affected: □ Upper Back □ Lower Back □ Shoulder □ Arm □ Elbow □ Wrist □ Leg □ Knee □ Ankle □ Foot  Side Affected: □ Left □ Right □ Both □ Neck □ Head □ Other Body Part Affected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| **Lift / Carry** | **Not at**  **All** | **Rare** | **Occa**  **sional**  **0-33%** | **Fre-**  **quent**  **34-66%** | | **Contin-**  **uous**  **67-100%** | |  | | | | | | | | **Comments:**   |  | | --- | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | | |
| **Hand, wrist, shoulder activities** | | | | | | | |
| 0-9 lbs | □ | □ | □ | □ | | □ | | **Avoid prolonged, repetitive or forceful:** | **Not at**  **All** | **Rare** | | **Occa**  **sional**  **0-33%** | **Fre-**  **quent**  **34-66%** | | **Contin-**  **uous**  **67-100%** |
| 10-19 lbs | □ | □ | □ | □ | | □ | | **Gripping/grasping** | □ | □ | | □ | □ | | □ |
| 20-29-lbs | □ | □ | □ | □ | | □ | | Repetitive wrist motion | □ | □ | | □ | □ | | □ |
| 30-39 lbs | □ | □ | □ | □ | | □ | | **Reaching:** | □ | □ | | □ | □ | | □ |
| 40-49 lbs | □ | □ | □ | □ | | □ | | Above shoulder | □ | □ | | □ | □ | | □ |
| No lift from floor | □ | □ | □ | □ | | □ | | At shoulder height | □ | □ | | □ | □ | | □ |
|  |  |  |  |  | |  | | Below shoulder | □ | □ | | □ | □ | | □ |
| **Push / Pull without resistance** | | | | | |  | | **Restrictions: circle:** | | | | | | | |
| 0-19 lbs | □ | □ | □ | □ | | □ | | Keyboard hrs/shift | 0 | 1-2 | | 3-4 | 5-6 | | 7 |
| 20-40 lbs | □ | □ | □ | □ | | □ | | Writing hrs/shift | 0 | 1-2 | | 3-4 | 5-6 | | 7 |
| > 40 lbs | □ | □ | □ | □ | | □ | | **Total spread out evenly over shift at \_\_\_\_\_\_intervals** | | | | | | | |
| Bend | □ | □ | □ | □ | | □ | | **Change positions every:** | | | | | | | |
| Twist / turn | □ | □ | □ | □ | | □ | | As needed □ |  | Worksite stretches □ | | | | | |
| Kneel / squat | □ | □ | □ | □ | | □ | | Half hour □ |  | Exercises □ | | | | |  |
| Sit | □ | □ | □ | □ | | □ | | One hour □ |  | (per handout) | | | | | |
| Stand / walk | □ | □ | □ | □ | | □ | | Two hours □ |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |
| Ladder/stair climb | □ | □ | □ | □ | | □ | |  |  |  | | | | |  |
| ***INSTRUCTIONS*** | | | | | | | | | | | | | | | | | | |
| □ Keep wound clean and dry. Change dressing every\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| □ Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| □ Ice \_\_\_\_\_\_\_\_ min.\_\_\_\_\_\_\_\_\_ □ Heat \_\_\_\_\_\_\_\_ min.\_\_\_\_\_\_\_\_\_ □ Splint / brace \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| □ Referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Follow-up appointment scheduled for:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| **THIS TREATMENT HAS BEEN DISCUSSED WITH THE EMPLOYEE** | | | | | | | | | | | | | | | | | | |
| Clinic: | | | | | Clinic Address: | | | | | | | | | License / Regis#: | | | | Date of Exam: |
| Health Care Provider Name (printed): | | | | | Health Care Provider’s Signature: | | | | | | | | | Phone: | | | | Fax: |