Mankato Area Public Schools

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

**Your Packet Includes:**

 **1. Supervisor’s Report**

 **2. First Report of Injury**

**As of July 1, 2019 the district has a new Workers’ Compensation Carrier:**



**These are Mankato facilities to select from when you have a work related injury and need medical attention.**

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| --- | --- | --- | --- |
| Facility Name | Contact | Specialty | Address |
| Mayo Clinic Health Systems | Linda Boylan-Starks, CNP507-304-7370 | Occupational Medicine | 1400 Madison Ave, Suite 100AA Mankato MN 56001 |
| East Ridge Mayo Clinic | 507-304-7000 | Urgent Care | 101 Martin Luther King DriveMankato, MN 56001 |
| Orthopaedic & Fracture Clinic | 507-386-6600 | Orthopedics | 1431 Premier DriveMankato, MN 56001 |
| Mayo Clinic Health Systems | 507-625-4031 | Primary Care & ER | 1025 Marsh St. Mankato MN 56001 |
| Advanced Chiropractic of Mankato | 507-385-2000 | Chiropractic | 315 Webster AveNorth Mankato, MN 56003 |

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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 🞎 |
|  |  |  |
| JOB TITLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | SERVICE WITH THE COMPANY:\_\_\_\_\_\_\_\_\_\_\_\_\_ | YEARS IN PRESENT JOB?:\_\_\_\_\_\_\_ |
|  |  |  |
| **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 🞎 |
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| **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 🞎 |
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| **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 along with Employee’s Report of Injury.** |

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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. |
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| 2. Referred to in question #1. |
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| 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? |
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| 4. Was the work area clean and well organized? (i.e., scraps on the floor, blocked aisles, wet floor, spilled food, etc.) |
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| 5. Was there inadequate supervision? Did horseplay or practical jokes contribute to the accident? |
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| 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.) |
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| 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.) |
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| 8. Did this person have any bodily defects which might have help cause the accident? (i.e., poor vision, previous back injury, etc.) |
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| 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? |
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| **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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| As supervisor, do you feel that this injury should be covered by workers’ compensation benefits? As a general rule, if the employee is injured while at work, that injury is covered under workers’ compensation. However, if you as supervisor have reason to suspect that the injury did not occur at work, please tell us. This is only an opinion and by itself will not deny benefits. |

Updated 11/1/2016

Mankato Area Public Schools



# EMPLOYEE’S FIRST REPORT OF INJURY

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| --- | --- | --- |
| EMPLOYEE NAME (Last, First, Middle) | EMPLOYEE SOCIAL SECURITY NO | DATE OF CLAIMED INJURY |
| HOME ADDRESS (Include City & Zip) | SEX \_\_\_\_\_\_\_Male  \_\_\_\_\_\_\_Female | MARITAL \_\_\_\_\_\_\_MarriedSTATUS \_\_\_\_\_\_\_Not | Work Start Time:\_\_\_\_\_\_\_A.M. \_\_\_\_\_\_ P.M. |
| OCCUPATION | DATE OF BIRTH: | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | DATE HIRED: | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| REGULAR DEPT. | DESIGNATED PHONE NO.: | APPRENTICE  \_\_\_\_\_\_No \_\_\_\_\_\_Yes |
| WAGE INFORMATIONAverage Wage / Week | RATE PER HOUR | DAYS PER WEEK | HOURS PER DAY |
| EMPLOYMENT STATUS \_\_\_\_\_\_\_\_Full Time \_\_\_\_\_\_\_\_Part Time \_\_\_\_\_\_\_\_Seasonal |
| OCCURRENCE Place (include dept. & full address)On Employer’s Premises? \_\_\_\_YES \_\_\_\_NO | Date of First Day of Lost Time  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ | Date Employer was Notified of Injury\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| Return to Work Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ | Date Employer was Notified of Lost Time  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| Date of Death  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ | **Time of Day of Injury** **\_\_\_\_\_\_\_\_\_\_A.M. \_\_\_\_\_\_\_\_\_P.M.** |
| **Describe how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** Example: “Worker was driving lift truck with a pallet of boxes when the truck flipped, pinning worker’s foot.  |
| **What was the Injury or Illness? (include the parts of the body involved).** Example: chemical burn to left hand, broken left leg, pain in left wrist. |
| **What tools, equipment, machines, objects, or substances were involved?** Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. |
| **1. Was a STUDENT involved in this injury?** **□ YES □ NO** If yes, complete and attach a copy of the filled out Pupil Injury Report.EXPOSURE INCIDENT is an individual’s blood or other potentially infectious body fluid contacting another person’s mucous membrane, non-intact skin, or a puncture into the skin. **2. Was an EXPOSURE involved?**  **□ YES □ NO**  **If yes, fill out the Employee Exposure Information form with your site NURSE.** |
| PHYSICIAN (Name, Title, Address, Phone)(Fill in only if you saw a doctor for this injury.) | HOSPITAL / CLINIC (Name & Address) |
| WITNESS (Name & Phone Number) |
| Date this form was completed  |

**Return this form to your Supervisor and send or fax to the Central Business Office within 24 hours.**

**FAX: 387-4033 Attn: Director of Facilities** (Form Revised 11/1/2016)

Any person who with intent to defraud receives workers’ compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3.