What to do in the event of an On-the-Job Injury:

Employee Instructions (Mandatory)

- **All on-the-job injuries/incidents must be reported by the end of the shift in which the injury/incident occurred, or as soon as reasonably possible if off-site treatment was obtained.** On-the-job incidents/injuries should be reported on the City of Charleston Report of Incident and Injury Form. On-the-job incidents/injuries not reported in accordance with City policy may impact the status of your claim, including the delay or denial of your claim/benefits.

- When an on-the-job injury occurs, immediately notify your supervisor and/or Department Head. If your supervisor and/or Department Head is unavailable, notify Tim Campbell, Safety Coordinator at (304)348-8015 or via email at tim.campbell@cityofcharleston.org.

- Submit your completed Report of Incident and Injury Form and Workers' Compensation TTD Benefits or Sick Leave Election of Option Form to Tim Campbell.

- If the injury is not an emergency or life threatening, employees are encouraged to seek medical treatment at an urgent care facility. **The City of Charleston Employee Wellness Center DOES NOT see or treat employees who have sustained an on-the-job injury.**

- If you desire to seek medical treatment, you should take a Transitional Duty Evaluation Form and attached letter with you on your **initial visit** with your treating physician. Request that your physician complete and return the Transitional Duty Evaluation Form to Tim Campbell at (304) 348-8055 or via email at tim.campbell@cityofcharleston.org.

- Employees should contact Tim Campbell at (304) 348-8015 or via email at tim.campbell@cityofcharleston.org in order to provide an update with respect to extent of his/her injury, return-to-work status, next appointment, etc.

- Please submit copies of all documents/forms from your treating physician's visits related to your on-the-job injury to Tim Campbell by secure fax at (304) 348-8055 or via email to tim.campbell@cityofcharleston.org.

If you have any questions, please feel free to contact Tim Campbell, Safety Coordinator at (304) 348-8015 or via email at tim.campbell@cityofcharleston.org

CITY OF CHARLESTON
Report of Incident and Injury

General Information

Employee Name: **Employee No.:**

Department: Select Department **Position:** Select Position

Supervisor: **Incident Date & Time:** Select AM/PM

Address/Location of Incident:

Describe what the employee was doing immediately prior to the incident:

Date & Time Employee Shift Began: Select AM/PM

Incident Details

What equipment, substance or other object caused the incident:

Name of individual(s) first notified:

List the name(s) of any witness*

Incident Date & Time: Select AM/PM

*Attach witness statement for each witness

Check Body Part(s) or Area(s) affected and select right,left, or both, if applicable): (Check all that apply)

- ☐ Ankle Select R, L or B
- ☐ Arm Select R, L or B
- ☐ Chest
- ☐ Elbow Select R, L or B
- ☐ Eye Select R, L or B
- ☐ Face
- ☐ Finger Select R, L or B
- ☐ Foot Select R, L or B
- ☐ Groin
- ☐ Hand Select R, L or B
- ☐ Head
- ☐ Hip
- ☐ Internal
- ☐ Knee Select
- ☐ Leg Select
- ☐ Lower Arm Select
- ☐ Lower Back
- ☐ Lower Leg Select R, L or B
- ☐ Neck
- ☐ Respiratory
- ☐ Shoulder Select R, L or B
- ☐ Thumb Select R, L or B
- ☐ Toes Select R, L or B
- ☐ Trunk Select R, L or B
- ☐ Upper Arm Select R, L or B
- ☐ Upper Back
- ☐ Upper Leg Select R, L or B
- ☐ Wrist Select R, L or B
- ☐ Other (describe below)

Injury Source: (Check all that apply)

- ☐ Automobile Accident
- ☐ Burn
- ☐ Caught In/Under/Between
- ☐ Cut / Puncture / Laceration
- ☐ Electric Shock
- ☐ Equipment Accident
- ☐ Fall
- ☐ Hand Tool(s)
- ☐ Injured by Animal/Insect
- ☐ Machine Injury
- ☐ Material Handling
- ☐ Portable Power Tool(s)
- ☐ Repetitive Motion
- ☐ Slip or Trip
- ☐ Sprain / Strain
- ☐ Struck By/Against/Object
- ☐ Struck By/Against/Person
- ☐ Other (describe below)

Treatment

Medical Treatment: (Check one)

☐ On-site First-aid only ☐ Urgent Care Facility ☐ Emergency Room ☐ Other (describe below)

Name and location of medical facility (enter N/A if employee received no treatment):

Was the employee admitted to the medical facility? Select Yes or No

Preparer's Name (print) **Preparer's Signature** **Date**

Employee's Signature **Date**

By signing above, the employee does hereby authorize any person or persons who have in the past, or will in the future medically amend, treat or examine me or any person who may have information of any kind which may be used to arrive at a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to the City, or any individual or entity authorized by the City. A copy of this form shall also serve as an original. **A completed report must be sent to the Safety Coordinator no later than the end of the shift in which the incident/ injury occurred, or as soon as reasonably possible if off-site medical treatment was obtained. Completed forms can be faxed or emailed to (304) 348-8055 or safetycoordinator@cityofcharleston.org.**

Revised 01/05/2017

CITY OF CHARLESTON
Statement of Witness to Incident

Section I: Incident Identifying Information

Name of Employee Involved in Incident:

Department: Select Department **Date of Incident:**

Section II: Witness Statement Name:

Phone No.:

Address:

City: **State:** **Zip:**

Did you observe an incident involving the employee referenced in Section I above? ☐ **Yes** ☐ **No**

If "Yes", what was the date and time of the incident? Select AM/PM

If "Yes", described what you observed:

If you checked "No" above, how did you learn about the incident?

Name of Witness (please print)

Signature **Date**

WORKERS' COMPENSATION TEMPORARY TOTAL
DISABILITY BENEFITS OR SICK LEAVE BENEFITS
ELECTION OF OPTION

Employee Name:	Position Title: Select Position
Date of Injury:	Claim No. (if known):
Department: Select Department	Superviosr:

To the Employee: ***Please submit this completed form to Tim Campbell, Safety Coordinator.***
If your on-the-job injury will result in you missing three (3) or fewer consecutive scheduled work days, you are not eligible to receive temporary total disability ("TTD") benefits (i.e. wage replacement). However, any medical expenses incurred or any treatment of covered conditions as a result of the injury, if any, will be paid. Should your on-the-job injury result in you missing more than seven (7) consecutive scheduled work days, you may be eligible for Workers Compensation wage replacement beginning the date of injury, if eligible and approved.

If you are absent from work due to a work-related injury, you must choose to receive ***either*** Temporary Total Disability benefits (TTD benefits) from Workers' Compensation or paid sick and/or vacation leave, according to the Workers' Compensation Temporary Total Disability Benefits/Sick Leave policy. If you elect to receive TTD benefits, you may use sick leave ***until*** you receive your initial TTD benefit check; however, this leave will be restored when you reimburse the City the net value of the paid sick leave used, according to the provisions of this policy.

☐ **Option 1**

I elect to receive Workers' Compensation TTD benefits; however, I understand that I may use sick leave and/or vacation leave ***only until*** I receive my initial TTD benefits check. I understand that while receiving TTD benefits, I will be in a leave of absence without pay status. During this leave of absence without pay, I understand that I will accrue vacation leave. I **will not accrue** sick leave and I **will not be paid** for holidays during this leave of absence without pay.

☐ **Option 2**

I elect to receive sick leave and/or vacation leave benefits instead of Workers' Compensation TTD benefits for the period that I am absent from work due to a work-related injury. While I am receiving paid leave benefits, I understand that I will continue to accrue vacation leave, sick leave, and be paid for holidays that occur during this period. After I exhaust my sick leave and/or vaction leave, I understand that I am eligible to receive TTD benefits during any remaining period of absence from work due to a compensable injury. If I receive TTD benefits, I understand that while receiving these benefits, I will be in a leave of absence without pay status. During this leave of absence without pay, I understand that I will accrue vacation leave. I **will not accrue** sick leave and I **will not be paid** for holidays during this leave of absence without pay.

Employee's Statement: I understand that I must choose **either** Workers' Compensation TTD benefits or paid sick leave and/or annual leave, and that I am not legally entitled to both for the same period. I understand that if I elect to receive TTD benefits and choose to receive paid sick leave and/or annual leave until I receive my initial TTD benefits check, I must reimburse the net value of the paid leave to my employer, who will then restore that leave. If I fail to reimburse my employer the net value of the paid leave used, I understand such amount will be deducted from future wage payments.

Employee's Signature: _____ **Date Submitted:** _____

CITY OF CHARLESTON
OFFICE OF HUMAN RESOURCES
P.O. BOX 2749
CHARLESTON, WV 25330
(304) 348-8015

LETTER TO TREATING PHYSICAN

Re: Transitional Duty Evaluation Form

Dear Medical Provider:

You are currently treating a valuable employee of the City of Charleston (the "City") for an on-the-job injury/illness. The City maintains a **Return-to-Work** program which is designed to assist an injured employee in the transition to his/her normal work assignment as soon as medically possible.

We may be able accommodate any restrictions you believe are medically necessary to ensure a smooth transition and full recovery, including, but not necessarily limited to modified duties/responsibilities, work hours and/or other accommodations for the continuation of medical treatment during recovery.

Please complete the attached Transitional Duty Evaluation Form which describes the restrictions, if any, you believe are medically necessary to our employee's recovery. The City's objective is to return the employee to his/her pre-injury work assignment, and we ask that you keep this objective in mind when establishing a treatment plan and/or restrictions. You may return the completed form to us at via our secure fax line at (304) 348-8055 or email to tim.campbell@cityofcharleston.org.

Should you have any questions, or need any further information, please contact me at (304) 348-8015. Thank you for your attention and cooperation.

Sincerely,

Tim Campbell
Safety Coordinator
CITY OF CHARLESTON

Encl: Transitional Duty Evaluation Form

Form OIC-WC-1

West Virginia Workers' Compensation
Employees' and Physicians' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I — Employee's Claim Information

Insurer: City of Charleston **Third-Party Administrator:** Risk Management Services Company

1. Name: (Last): (First): (M.I):

2. Address: **3. Telephone:** ( ) -

City: State: Zip: **4. Social Security No.:** - -

5. Date of Birth: _____/_____/_____ **6. Sex:** ☐ M ☐ F **7. Marital Status:**

8. Date of Injury or Last Exposure: _____/_____/_____ **Time:** ☐ a.m. ☐ p.m. **9. Time You Began Work on Date of Injury:** ☐ a.m. ☐ p.m.

10. Date You Stopped Working Due to Injury: _____/_____/_____

11. Have You Retired? ☐ yes ☐ no If "yes," what was the date you retired: _____/_____/_____

12. Employer's Name: Supervisor's Name:

Address:

City: State: Zip: Telephone: ( ) -

13. Job Title/Description:

14. Body Part(s) Injured:

15. Describe How Your Injury Occurred (Specify the cause, what you were doing, and equipment/objects involved):

16. Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address where injury occurred:

17. Please Identify Any Witnesses to Your Injury:

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.

Employee's Signature: _____ **Date:** _____/ _____/ _____

Section II — All Information Must Be Completed by Initial Healthcare Provider

1. Name of Physician/Hospital: **2. FEIN/Social Security No.:** - -

3. Address:

City: State: Zip: **Telephone:** ( ) -

4. Date of Initial Treatment: _____/_____/_____ **5. Date Patient May Return to Work:** _____/_____/_____

6. Have you advised the patient to remain off work 4 or more days?

☐ Yes. Indicate dates: from to

☐ No. If "no," is the patient capable of ☐ Full Duty ☐ Modified Duty If the patient is capable of returning to modified duty, specify any limitations/restrictions:

7. Condition is a direct result of: ☐ Occupational Injury? ☐ Occupational Disease? ☐ Non-Occupational Condition?

8. Did this injury aggravate a prior injury/disease? ☐ Yes ☐ No. If Yes, explain:

9. Description of injury or occupational disease:

10. Body part(s) injured: **11. ICD9-CM Diagnosis Code(s) in order of severity:**

12. Name of physician referred to: **13. If the patient was hospitalized, where?**

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia's Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Signature: _____ **Date:** _____/_____/_____

City Of Charleston

Fax to 304-348-8055

TRANSITIONAL DUTY EVALUATION FORM - *To Be Completed by Attending Physician*

Patient's Name	(Last)	(First)	(M.I.)
Date of Initial Injury/Illness		Date of Treatment	
Brief Explanation of Diagnosis/Condition			
Based on the above description of the patient's current medical problem, I recommend the following:			
☐ Patient may return to work with **no limitations**		On this Date:	
☐ Patient may return to work **with limitations** (listed below)		On this Date:	

Check all that apply as they relate to the above condition:

☐	**Sedentary Work** – Lifting 10 lbs maximum and occasionally lifting or carrying such articles as dockets, ledgers and small tools. Work essentially involves sitting and is considered sedentary if only a small amount of walking and standing is necessary to carry out duties.	1.	In an eight hour work day, patient may: a. Stand/Walk: ☐ None ☐ 1-4 hours ☐ 4-6 hours ☐ 6-8 hours b. Sit: ☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours c. Drive: ☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours
☐	**Light Work** – Lifting 20 lbs maximum and frequent lifting or carrying of objects up to 10 lbs. Work is classified as light if it requires walking or standing to a significant degree (regardless of weight lifted) or involves sitting most of the time with a degree of pushing and pulling of arm or leg controls.	2.	Patient may use hand(s) for repetitive: ☐ Single Grasping ☐ Fine Manipulation ☐ Pushing/Pulling
☐	**Light-Medium Work** – Lifting 30 lbs maximum and frequent lifting or carrying of objects weighing up to 20 lbs.	3.	Patient may use foot/feet for repetitive movement, as in operating foot controls. ☐ YES ☐ NO
☐	**Medium Work** – Lifting 50 lbs maximum and frequent lifting or carrying of objects weighing up to 25 lbs.	4.	Patient may (fill in as needed, including any other instructions / limitations or prescribed medications):
☐	**Light-Heavy Work** – Lifting 75 lbs maximum and frequent lifting or carrying of objects weighing up to 40 lbs.		
☐	**Heavy Work** – Lifting 100 lbs maximum and frequent lifting or carrying of objects weighing up to 50 lbs.		
Do these restrictions apply to activities outside of working hours? YES NO If no, explain:			

☐ These restrictions are in effect until (date):	☐ Or until patient is re-evaluated on (date):
☐ **Patient is totally incapacitated at this time, and a re-evaluation is scheduled on (date):**	

Referred To: ☐ None	☐ Private Physician	☐ Return Here	☐ A Consultant	☐ Other (specify):
Physician's Signature				Date

Patient's Authorization to Release Information: I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer or representative.

Patient/Employee's Signature	Date

FAX

CITY OF CHARLESTON
OFFICE OF HUMAN RESOURCES
P.O. BOX 2749
CHARLESTON, WV 25330
(304) 348-8015
(304) 348-8055

To: Tim Campbell, Safety Coordinator **From:**

Fax: (304) 348-8055 **Pages:**

Re: Workers' Comp / Return to Work

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments: